Staff and patient experiences of seclusion and special observations in high secure care

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Abstract

This study focuses on staff and patient experiences of seclusion and special observations as planned interventions in the management of violence and aggression in high secure forensic care. Restrictive and potentially coercive approaches to the management of disturbed behaviour, these controversial interventions remain commonplace in a variety of psychiatric settings despite the lack of evidence about either efficacy or therapeutic value.

Investigation of staff or patient experiences of both seclusion and the use of special observations for the management of violence and aggression remain poorly researched areas of clinical practice in both forensic and non-forensic settings. Exploration of their use within a high secure setting provided opportunity to examine these approaches within a system that has historically attracted adverse attention and criticism as a result of punitive and custodial sub-cultures.

A grounded theory approach was used to understand meaning, feelings and views attributed to these interventions by both staff and patients. This provided insight into the effects and impact of these interventions upon the participants, and examination of the relationship of the approaches to the pervading culture within a high secure forensic environment. With the study undertaken by a senior nurse manager at the research site there was opportunity to adopt a reflexive approach and exploration of issues from an insider perspective.

The findings demonstrate how the social, cultural and temporal influences present within a high secure psychiatric setting can impact upon the perceptions of care and treatment, and how the use of seclusion and special observations can impact upon the lives of those subject to their restrictions and those employing them in the course of their work. The findings provide insight into how patients and staff perceive and respond to fear and threat in their immediate environments and how the use of seclusion and special observations can impact and influence these perceptions. The nature of interpersonal relationships between both parties is shown to be significant in the views and opinion regarding acceptability and

justifiability of both seclusion and special observations, and in the perception of care and treatment during their use. The study emphasises and highlights how a high dependency area within a high secure forensic setting provides a distinctive clinical environment; one in which both staff and patients perceive the ward to be a hostile and, at times, frightening place to live or work. The study illustrates how both staff and patients use protective strategies to survive the day to day stressors and antagonisms experienced as part of life in a high secure setting. It highlights how restrictive practices such as seclusion and special observations contribute, impact upon, and even magnify the significance of these antagonisms and threats and can influence subsequent responses.

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CHAPTER 1 – INTRODUCTION

Part One: Introduction

1.0 Introduction and rationale for the study

This study focuses upon the use of seclusion and special observations as planned interventions in the management of the risk of violence and aggression within a U.K. high secure forensic service. It specifically explores the impact of these highly coercive and potentially invasive interventions upon the experiences and perceptions of both staff and patients within the highly structured clinical environment of a high secure hospital; services with their cultures historically based largely upon control and custody.

The introduction will demonstrate the relevance of studying these interventions together; particularly within the socio-cultural context of a high secure setting, and at the expense of other forms of aggression management. Further, it will present a framework for the study by providing an overview of the interventions themselves, of the historical and contemporary provision of high secure services in U.K., and of the role of seclusion and special observations in the maintenance and promotion of high secure organisational culture. It will highlight the emerging role of special observations, and demonstrate how the historical emphasis and reliance upon the use of seclusion in the management of violence and aggression is now often being complemented, and at times, replaced by the use of special observations.

1.1 The argument for seclusion and special observations

There are a number of specific interventions that are commonly used in management of violence and aggression within various psychiatric settings. Often seen as the mainstream repertoire of approaches these largely include rapid tranquilisation, manual physical restraint, the use of mechanical restraints, seclusion, and special observations.

Despite this diverse range of interventions available, however, the actual preferred choice can often prove culturally dependent. Favoured approaches to the management of violence and aggression are frequently the product of locally derived cultural and philosophical perspectives, bound by overriding national

guidance and legislation, and subject to the "sociocultural traditions" and "treatment customs" in individual settings (Raboch et al, 2010, p1016).

These variances have been noted in comparative studies on the use of coercive measures at both international and local levels (Bak & Aggernaes, 2012; Bowers et al, 2007; Crenshaw & Francis, 1995; Janssen et al, 2008; Steinert et al, 2010). These have highlighted how some interventions are utilised more readily or more cautiously not just across different countries but even within different regions or services within single jurisdictions. It is a result of such variations in preferred interventions that provide the rationale for the study of seclusion and special observations in the absence of the other mainstream approaches.

In focusing upon specific strategies for the planned management of the risk of violence and aggression the study differentiates between those approaches that are designed to provide an element of immediate crisis intervention and those that are utilised for the more long term management of risk; interventions whose continuance are often planned or prescribed even if initiation was in response to an acute situation. It is by focusing upon these longer term strategies of patient management that the socio-cultural influences present within, and exerted upon, a clinical environment can be explored in relation to the staff and patient experiences of both seclusion and special observations in high secure care.

These differences between crisis intervention and longer term management of risk of violence are clearly evident at the research site (see Table 1 below). This highlights how seclusion and special observations are the methods of choice for risk management within this specific service. It can be seen that the use of rapid tranquilisation as a means of crisis intervention is rarely used, and the use of mechanical restraint never utilised. Similarly the use of prolonged manual restraint is never used for the planned management of violence or aggression, with its primary use being a short term intervention to obtain physical control of a situation to prevent further acting out. Often, subsequent to such control, manual physical restraint may be used in the conveyance of the patient to a designated seclusion room if required.

This therefore allows a clear distinction to be drawn between interventions that are primarily used to provide immediate crisis intervention, such as rapid tranquilisation or manual physical restraint, and those interventions which are used in high secure services to manage the risks of violence and aggression in the longer term.

	Episodes of Seclusion	Episodes of Special Observation	Episodes of Mechanical Restraint	Episodes of Rapid Tranquilisation	Episodes of prolonged physical restraint
2007	140	293	0	3	0
2008	140	296	0	5	0
2009	163	240	0	3	0
2010	154	218	0	1	0
2011	129	205	0	4	0
2012	191	198	0	2	0

Table 1: Use of coercive interventions at research site to manage violence & aggression

The longer term nature of managing the risk of violence and aggression through the use of restrictive interventions such as seclusion and special observations have the potential to impact cognitively, emotionally, socially and physically upon both staff involved in their initiation and implementation, and patients subject to their restrictions. It is the potential effects of these longer term methods of managing violence and aggression, and their wider impact upon culture and control that give the interventions their particular significance to this study.

Furthermore, despite being part of the mainstream strategies used to manage violence and aggression, both seclusion and special observations remain controversial, coercive and invasive (Whittington et al, 2006), With respect to seclusion, much of the controversy has arisen from concerns on humanitarian, ethical or legal grounds (Meehan et al, 2000), concerns over neglect and abuse (Lendemeijer & Shortridge-Baggett, 1997), recognition of its potentially harmful and traumatising effects (Holmes et al, 2004; Frueh et al, 2005), and from the lack of controlled trials to support efficacy (Sailas & Fenton, 2000; Muralidharan & Fenton, 2006) or proven therapeutic benefit (Muir-Cochrane, 1995). Within both the literature and clinical practice opinion is often divided and polarised between protagonists supporting its use as a valid tool in the management of challenging behaviour, and antagonists who consider it out dated, damaging and punitive. Whether supportive of its use or abolition, what is evident from the literature is that

the issue of seclusion in particular can engender strong emotion, divide opinion and fuel clinical, academic and legal debate and challenge.

In contrast, however, the use of special observations for the management of violence or aggression remains a poorly researched area of psychiatric practice. Traditionally used for the management of patients with self injurious or suicidal propensities, their use in the care and treatment of patients presenting as challenging and potentially violent appears increasing commonplace. Indeed Bowers et al (2000) noted 80% of health authorities adopting this approach. Despite its increasing prevalence, however, there remains a paucity of literature available on its use for these clinical reasons, and, as with seclusion, little in the way of evidence to support efficacy or therapeutic value (Bowers & Park, 2001).

This study, therefore, explores the use of two highly contentious, coercive, and potentially restrictive interventions within an environment that itself has historically been more closely associated with penal culture than the philosophies of care. It examines their use within the socio-cultural context of a psychiatric system that historically controls and dominates, and where little is known about staff and patient experiences of working or living within such institutions. The specific relationship of seclusion and special observation experiences to the pervading culture and philosophy of care has not been previously been the primary focus of research within a U.K. high secure environment, and is an important element to understand if standards of care are to be improved and changes to practice implemented.

It is in the examination of the staff and patients' experience of seclusion and special observations that enlighten us to the culture, values, and philosophies that dominate high secure psychiatric care in U.K. It allows comparisons between contemporary practice and the cultures, systems and processes that Goffman (1961) identified as characteristic of a 'total institution', and contributes to what van der Merwe et al (2009) highlighted as a need for further research into the use of containment measures in forensic settings.

The study also comes at a time when the use of seclusion has come under specific scrutiny within the UK high secure system, and ultimately led to a

significant organisational drive to reduce the levels of use at the research site. This has subsequently seen the practice often replaced or supplemented by the imposition of special observations as either an adjunctive or alternative intervention to seclusion. Therefore, whilst the use of seclusion remains an important tool in the repertoire of interventions available to staff within a high secure setting, there is increasing use of special observations within the UK high secure services to manage the continuing threat and risk of violence and aggression. This increasing dependence and emphasis upon such a poorly researched and monitored intervention highlights the importance of further study and inquiry into its use from both staff and patient perspectives.

Whilst the study provides a contemporary account and examination into the highly restrictive practice of seclusion, it is in the emerging data and evidence around the use of special observations that propels the study beyond those previously undertaken and published on the use of restrictive practices in a high secure forensic setting. It is primarily in this study of special observations that our knowledge and understanding of the processes that govern, determine and influence coercive practice in a high secure setting are furthered. It is through this examination and inquiry that we come to learn of how special observations are becoming integral to the management of violence and aggression and how divergent opinion is between staff and patient groups on their use.

A further significant element to the study is in the specific positionality of the researcher as a senior nurse manager at the research site. As a practising forensic psychiatric nurse and senior manager the author brings to the research process not only personal experience of seclusion and special observations, but also knowledge, values and judgements about both them and the high secure system. It is recognised and accepted that these values and judgements have the potential to influence direction, analysis and interpretation throughout the process.

It is through the use of reflexivity that the author addresses these potential biases and influences and provides the reader with a lens through which to view the research process; its findings and its conclusions. It is though this process of reflexivity that transparency is given to the process and credibility to the author as

researcher. Reflexivity is discussed and explored in detail in the methodology chapter.

1.2 Thesis outline

The thesis starts by highlighting key aspects of high secure provision in the U.K. today; providing the context for the interventions as currently used in high secure care. It is in this recounting that the potential differences to general psychiatric practice become evident. The thesis then explores the relevant issues pertaining to the use of seclusion and special observations, analysing the previous literature on the experiences of staff and patients to both practices; drawing attention to points of relevance for this study and highlighting gaps in the literature where appropriate. This part of the thesis provides an awareness and understanding of both interventions and illustrates the controversial and often complex nature of their use. It also provides the basis for understanding the findings.

The methodology chapter discusses the suitability of grounded theory as the methodological approach chosen for the study; highlighting aims and research design, and describing the research site, clinical setting and samples groups. This chapter highlights the reflexive nature of the study given the unique positionality of the author, and discusses the phases of the study, methods of data collection and analysis. It concludes by addressing methodological rigour.

The study findings are presented as separate and distinct elements to reflect the key perspectives of the respondent groups. The findings themselves demonstrate how both staff and patients experience antagonisms, anxieties, and annoyances within what they often hold to be a hostile, threatening and stressful environment. It is shown how the nature of staff-patient relationships and dyadic encounters can influence perceptions of these antagonisms and whether or not they are subsequently perceived as threats. It is from these perceptions of threat that protective cognitive, emotional and behavioural responses are utilised; serving as survival strategies to promote physical and psycho-social functioning and wellbeing. The findings highlight the role of seclusion and special observations in this process. It illustrates how they are often perceived as stressors and antagonisms with the potential to magnify the intensity of everyday annoyances,

concerns, anxieties and frustrations, and how impact and influence the psycho-social processes of adaptation noted by Goffman (1961) in his observations and descriptions of 'total institutions'. The findings further highlight the relationship of both interventions to the ward and organisational cultures of a high secure clinical environment, and how they are integrally entwined with the concepts of control and compliance.

The thesis concludes with a discussion chapter that considers the relevance of the findings; exploring their relationship to existing literature and highlighting where it adds to this. It identifies both similarities and differences in the perceptions, experiences, and responses of staff and patients to perceived threat and stress. It consolidates the framework described in the findings chapters in support of a theoretical explanation and interpretation of the experiences of staff and patients within this clinical setting, and finally identifies limitations to the study and implications for practice.

Part Two: High Secure Psychiatric Care

1.3 Introduction to high secure care

This part of the chapter provides an introduction to high secure psychiatric care in the U.K, charting both its historical development and current service structure. It illustrates how traditional culture and practice have been criticised for their punitive, custodial and anti-therapeutic nature (Boynton, 1980; Blom-Cooper, 1992), and how contemporary services have proved slow to respond to calls for change (Richman & Mercer, 2000).

It is in reviewing the history of the high secure hospitals from their inception in the mid 19th Century that we can see how the insularity and reluctance to hold practice to account provided an opportunity for a culture of overt containment and control to flourish (Mason, 1995). Further, it is through exploration of this historical culture, and the ideals and values traditionally held important by both the staff and the organisations themselves, that we can see how these organisations were so reminiscent of the 'total institutions' described by Goffman (1961).

This study therefore offers opportunity to explore whether the traditionally overt punitive cultures reported as endemic within these organisations remain, or have been replaced by more subtle and covertly coercive means of exercising power and control. It is through reflection upon the significant markers within the history of high secure services that we gain appreciation of how custodial penal cultures became the norm, and how this system has responded to calls for change. It was the cultural influences historically prevalent within the high secure hospitals that allowed restrictive practices, such as seclusion, to become part of the 'cultural constitution" (Mason & Chandley, 1998, p90). It is from a review and examination of these interventions that we can come to appreciate not only the historical importance of seclusion and special observations within the high secure system, but also their importance, role and influence in maintaining current culture, practice ideals and philosophies of care.

1.4 Development of high secure services in U.K.

Tasked with providing "treatment under conditions of high security for those regarded as having dangerous, violent or criminal propensities" (H.S.M.O., 1959, Section 97), the high secure hospital system in the U.K. provides the interface between health care, prison and criminal justice systems (Dick et al, 1990). Arising from the reforms of mental health legislation in the mid nineteenth century, the development of the high secure system reflected the changing moral and philosophical thinking of the time in U.K. that called for the separation of treatment from incarceration and punishment of the mentally ill (Scull, 1990). It was from these changes that Broadmoor hospital emerged in 1863; the first purpose built high secure hospital, with Rampton, Moss Side and Park Lane hospitals later established as demand increased. The early 1990's would see Moss Side and Park Lane hospitals amalgamate to form Ashworth hospital; leaving just the three hospitals of Ashworth, Broadmoor and Rampton to provide services for England and Wales, and a fourth hospital, Carstairs, providing a similar function for Scotland and Northern Ireland.

Despite providing a specialised role for both the health and criminal justice systems, it would be over 100 years before the high secure hospitals were brought together as a coordinated service. Formally recognised within the 1959 Mental Health Act (HMSO, 1959) and subsequently classified as 'Special Hospitals' in the National Health Service Act (HMSO, 1977) it was not until 1989 that they were brought under one governing health authority; with the 'Special Hospitals Service Authority' (SHSA) commissioned with modernisation, bringing the hospitals into the NHS, and setting the agenda for the 1990's and beyond.

This task would prove difficult to achieve, however, with the concept of caring for the mentally ill on which secure services were founded (Scull, 1990) failing to prosper within these large isolated institutions (Boynton, 1980). Secrecy, insularity, and a reluctance to accept or embrace inspection of practice all encouraged and invited criticism, led to geographical, professional and cultural isolation (Boynton, 1980) and condemnation for their brutal and damaging regimes (Blom-Cooper, 1992). It would appear that care, therapy and treatment often suffered at the expense of security, control and containment (Boynton, 1980), with tensions arising between what Mason & Mercer (1998) note to be an extreme care

environment where the "values of custody, detention and imprisonment are interposed with those of care, consideration and compassion" (p2).

1.5 Key events in high secure history

This section will discuss several key events in the recent historical past of the high secure hospitals, ranging from the mid 1970's through to the present day. Whilst serious incidents have occurred throughout the history of the special hospitals, inclusive of escapes and murders, it was not until 1970's that the high secure hospitals appeared to attract the level of scrutiny, criticism and widespread interest it holds today; perhaps a result of widening access to emerging media technologies and changing societal values towards, and concerns over the plight of the mentally ill.

These events have each had significant impact upon the future direction and delivery of care within the special hospitals, often with wide ranging implications that have included questioning their continued existence (Blom-Cooper, 1992; Fallon, 1999). The inquiries resultant from these incidents have proved influential in determining current service structure, organisational values, and standards for practice; forcing these once secretive institutions to open their practice to inspection and scrutiny. Whilst some recommendations have been welcomed and embraced, all have been imposed and ultimately heightened interest in the services provided to a degree rarely seen with other health services. It is in understanding the nature of these incidents, the call for change in the subsequent inquiries and reports, and the lasting effects upon culture and practice within these organisations that we can identify the challenges each has faced in attempting to eradicate poor practice, repair esteem, morale and standing, survive the public and political pressures, and ultimately move forward. These incidents have impacted upon organisational culture, provided drivers for change and, perhaps most significantly, highlighted the continuing struggle between balancing security and therapy. In noting the nature of these events and the subsequent impact upon the hospitals it can be argued that irrespective of whether the historical priorities for the special hospitals have been ethical care or custody, by any measure they appear to have failed.

The first key event highlighted focused clearly upon security and arose with the escape of two patients from Carstairs hospital in 1976; an incident which resulted in the murders of a fellow patient, a nurse, and a police officer before the two patients were finally apprehended. The repercussions from this had significant impact upon the role of security within the high secure hospitals and provided it with heightened importance and influence. The subsequent independent inquiry report (Scottish Home & Health Department, 1977) became statutory reading for all staff in high secure hospitals throughout the U.K., and whilst always considered an intrinsic part of life in high secure hospitals, the Carstairs escape and murders clearly drove security to the top of the agenda for both ward based staff and management alike.

Further major incidents arose in the years following the Carstairs incident and primarily focused upon complaints about standards of practice; in particular the neglect, abuse and brutalisation of patients (Boynton, 1980; Blom-Cooper, 1992; Prins, 1993). Arising following investigative television documentaries, the inquiries into both Rampton (Boynton, 1980) and Ashworth (Blom-Cooper, 1992) hospitals had significant effects upon the future direction and delivery of care within the high secure system. These inquiries highlighted a lack of leadership, over-structured and inflexible regimes, and an "almost military insistence on conformity to strict disciplinary rules" (Boynton, 1980, p52). A catalogue of poor practice including physical abuse and assault on patients, brutal and dehumanising regimes, and inadequate management control were found to be commonplace (Blom-Cooper, 1992). Security was too often cited as an excuse to resist change and the inquiry into Rampton noted that the geographical, organisational, professional and social isolation had 'perpetuated old-fashioned staff attitudes" (Boynton, 1980, p21) and propagated a degree of "institutional inertia" (p78). Similar views were expressed in the Blom-Cooper report into Ashworth, leading its chairman, Sir Louis Blom-Cooper to profess that "some staff may feel shame that their place of work could be such a miserable place for patients" (vol1, p7) and subsequently recommending its closure.

Just seven years after the damning first inquiry into allegations of ill-treatment however, Ashworth hospital was subjected to a second major inquiry. This was commissioned on the back of serious allegations by a patient that

included a widespread lack of security within the personality disorder unit that included poor standards of searching, staff selling prescription medications to patients, alcohol and pornography being widely available, and the grooming of a visitor's young daughter by a known paedophile. This inquiry (Fallon, 1999) found that whilst perhaps exaggerated, the patient's account of events was largely true, finding that there was evidence of paedophilic grooming of the young child, of widespread and woeful disregard of security procedures, of poor leadership, and poorly functioning and supervised patient care teams. They noted the widespread view held within the hospital that the pendulum had swung too far from repression to liberalisation. For the second time in seven years an independent inspection into Ashworth hospital recommended its closure.

These public inspections and scrutiny of generalised practice have been accompanied during this period by additional inquiries into deaths of patients in seclusion at Broadmoor (Ritchie, 1985; Prins, 1993), patient on patient murders (Rowe, 1991, NHS London, 2009) and further high profile escapes; incidents that have helped maintain the heightened profile of the high secure hospitals, generated professional, academic and legal debate, and given rise to continued political sensitivity towards future role and function. It has been argued that it is hardly surprising that such incidents and subsequent criticism has occurred, however, and that scrutiny and scandal are an inevitability of such institutions (Glouberman, 1990; Gunn & Maden, 1998); a position further supported by Rowden (2000) when noting in the Guardian newspaper that "these troubled institutions remain on isolated sites, with deeply embedded cultures" and that "it is still likely that, despite valiant efforts ... scandal will yet again erupt in one of them".

1.6 Total Institutions

This section of the chapter discusses the concept of 'total institutions' as defined by Goffman (1961). It illustrates how not only the traditional services provided by the U.K. high secure services demonstrated elements characteristic of such institutions, but also how many aspects of current service provision can be seen to maintain these. It is in the comparisons of the high secure system to the distinctive features of 'total institutions' that enlightens us to the pervading culture of control and containment and from this, allows for an appreciation of the role of seclusion and special observations in the maintenance of this.

Goffman (1961) coined the phrase 'total institutions' as a means of defining those organisations in which there is total authority to control others, with the term often being applied to such organisations as prisons, hospitals, military organisations, monasteries and concentration camps (Goffman, 1961). It reflects the ability of the organisation to exert their power and control over their subjects to promote change of the individual, to mould conduct, and to substitute negative aspects of behaviour and thought. Behaviours considered inappropriate are replaced with those considered more appropriate and acceptable by the organisation.

'Total institutions' control all aspects of life; work, recreation, privacy, leisure, and sleep. They are all encompassing and provide both physical and social barriers to the outside world (Goffman, 1961). This is often achieved through the use of high walls, locked doors and other aspects of physical and procedural security; set up to separate and minimise exposure to external social influences. The organisation becomes the social world of the subject, a place in which it is envisaged that they will conform to the restrictions placed upon them, learn to adopt the subservient roles expected of them, and adjust to their institutional life. Organisational processes are aimed at extinguishing previous social roles and determining new ones (Goffman, 1961). In the case of hospitals the patient learns to play the patient role, and with staff to learn to work towards the expressed ideals of the organisation..

Within 'total institutions', the patients lives are controlled by the staff. The supervisors (*the staff and the management*) determine and govern all aspects of the patient's day, arrange schedules to provide order, meet basic needs, and maintain social distance from the subjects themselves. However, it has been argued that at times this has led not only to social control, but also to stigmatisation, dehumanisation and degradation (Malacrida, 2005); accusations made all too often towards the high secure hospitals.

In his description of 'total institutions', Goffman (1961) not only highlighted the physical and structural characteristics of these organisations, but also gave detailed accounts of the effects upon both staff and patients. He spoke of the psycho-social processes experienced by each group and of the specific behaviours

demonstrated in their efforts to develop a meaning and purpose to their lives; their responses and adaptations to their situation. Goffman (1961) spoke of the routines exerted upon the patients from admission, calling this a mortification process in which the patient is systematically stripped of previous social roles and identities and has to develop new roles to make sense of his predicament and status. This development of new roles is seen as a re-assemblance of identity and is often achieved by the use of a privilege system based upon rules, rewards and punishments. It is through this process that the patient learns to adapt to the system; and for the most part learns to gain rewards and avoid punishment.

In a similar vein, Goffman (1961) spoke of the effects of the 'total institution' upon staff. He spoke of the complexities of reconciling competing roles, values and obligations in the provision of care. He described the power relations between staff and patients, the divisions and social distance between both groups, and the role of the institution in maintaining these barriers. He sees this a a specific cultural world for the staff in which they adapt to meet the demands placed upon them in the control, management and responsibility to change those in their care.

It is through exploration of these specific psycho-social processes that we can come to learn of the cultures, values, ideals and opinions that develop within each group as a result of their situations. From a patient perspective this can often take the form of developing stories to account for their new found position and status; stories often concerned with self and at times self pity and the writing off of time spent in the institution. From a staff perspective, however, this is often through the adoption of the professed ideals of the organisation and the belief that their role is to enforce social control and manage patient hostility and demands. Goffman (1961) argues that in staff this may give rise to emotional conflict as a result of having to use physical force in the interest of the patient, or even at times in the interest of the organisation itself; conflict that at times is resolved through the enforcement of organisational rules, reinforcement of the patient's lowly social status, and the self justification of actions.

Descriptions of life in the 'total institutions' were based upon observations from work in USA in the late 1950's (Goffman, 1961). It is therefore important to determine the degree to which their defining elements have not only been

historically present within and characteristic of the U.K. high secure system, but more importantly to ascertain the degree to which current service provision maintains and promotes such organisational cultures, philosophies, and effects upon patients and staff. Significantly, to what degree both groups continue to experience elements of institutionalisation as a result of these characteristics, and the role of seclusion and special observations in this process.

Characteristics of 'total institutions' have been highlighted as being present within the traditional structures of the high secure system in U.K (Blom-Cooper, 1992; Boynton, 1980). The 1992 Inquiry into Ashworth hospital (Blom-Cooper, 1992, p152); specifically made reference to a continuing reliance upon "traditional routines and programmes associated with the concept of the total institution". It spoke of how behaviour considered inappropriate to agreed standards would be targeted and sanctions imposed upon those who failed to meet these standards; sanctions that traditionally included the use of coercion, punishment and, significantly, the use of seclusion and special observations (Mason, 1995). Patients were often held to account if they failed to participate in the work, leisure or social activities organised within the institution; if they failed to adapt and conform to their subservient patient role.

These reports highlighted how often the structures, rules, activities, and routines were designed and maintained for the benefits of the organisation; to benefit economies of scale, as opposed to the meeting of individual patient or staff needs. These included the structure of the patient's day, the privilege system based on rewards and punishments, the barriers to the external world and an over reliance upon security. They noted the pervading culture of 'them v us' and of the limited social mobility between groups noted by Goffman (1961) being very much in evidence. They found oppressive regimes that disenfranchised the patient and gave the staff the power, authority and tools to maintain both social and physical control; tools such as seclusion and special observations (Mason, 1995).

Whilst contemporary external scrutiny of the high secure hospitals demonstrate some evidence that the traditional ultra strict authoritarian and overtly punitive regimes may be less prevalent, many of the long standing routines characteristic of 'total institutions' remain (Chandley, 2007; Davies, 2004). Many of

the operational procedures designed as a means of ensuring the continued smooth and effective running of the hospital remain; transformed into institutional norms through custom and practice over many years. Indeed Davies (2004, p21) suggests that many of these features "are indeed essential for the institutions to fulfil their role", arguing the challenge to the high secure hospitals being how to minimise the negative consequences of such features without jeopardising safety.

These organisationally driven routines are at times at odds with the explicitly expressed philosophies of the high secure hospitals, however, and the advocating of a more patient centred approach to care and promotion of individual choice and empowerment. Despite these declarations of patient focused care and an outwardly endorsed liberalisation of regimes and professed move away from overtly punitive and coercive practices of old, life within the high secure hospitals continue reminiscent of the 'total institutions' noted by Goffman (1961).

Even now the enforced detention, patients within high secure hospitals continue to experience limited access to, and contact with, the outside world; with patients often spending years within the confines of the hospital. Security restrictions limit many of the outlets and avenues often taken for granted within wider society; with restrictions upon mail, the use of telephones, access to the internet, familial visits, and the censuring of television programmes, newspapers and periodicals all serving to reinforce reliance upon the organisation. The majority of the patient's work, leisure, social and private time continues to be planned around what would appear to be the needs of the organisation rather than the individual.

With the imposition of the safety and security directions for the high secure hospitals by the Department of Health (DoH, 1999, revised 2011) expectations for conformity, uniformity and compliance remain as evident as ever. Indeed these directions provide the high secure hospitals with clear guidance and expectations on a wide range of clinical and security issues governing such things as access to fresh air, access to computers and the internet, frequency of searches of the person and his possessions; even the type and volume of possessions a patient may have. The ability of the patient to self-determine many aspects of his daily life is stripped from him in the name of security. This can be seen to be akin to a

modern day mortification process that reinforces the social distancing between staff and patients.

This process of mortification, as with the inmates observed by Goffman (1961), starts on admission with the allocation of a hospital number, a taking of a security photograph, the reading of legal rights, the searching of all possessions, and restrictions upon social networking outlets. Patients on admission are forced to sit on a specialised chair that can detect metal that may have been secreted in body orifices, are subject to physical examinations, and often geographically restricted to specific areas of the ward. They may even have further restrictions placed upon them such as being placed in seclusion or on special observations in a bedroom devoid of furniture. The patients are expected to socialise, work and take meals with their peers irrespective of their ethnic origin, social background, or even offending history. They are expected to conform and adopt the patient role. They are educated to the rules of the organisation and the behavioural expectations that govern life within the ward. Importantly they are informed of how to gain rewards and avoid sanctions through compliance. It is of note, however, that the term punishment is not used in the official vocabulary of the organisation, despite the use of sanctions for transgressions to hospital policy or acceptable behaviours. Patients are expected to conform to hospital rules and to refrain from upsetting the smooth running of the ward.

Goffman (1961) described further elements of a 'total institution' as there being a single plan or aim of the organisation, this being imposed from the top and at the exclusion of patients in any decision making processes. This total authority and control of all aspects of organisational business was internally guarded, with only favourable elements of practice offered to the outside world. This insularity was very much characteristic of the traditional high secure hospitals and whilst integration into the NHS has brought with it external scrutiny, monitoring, benchmarking, and a drive to change practice and culture, some have argued that positive change has been a slow and laboured process.

Richman & Mercer (2000) noted the failed attempts at eliciting change at Ashworth following the 1992 Inquiry (Blom-Cooper, 1992). They found little positive change despite radical changes to internal and external managerial structures, the

provision of external monitoring arrangements, and attempts at diluting the entrenched attitudes of the nursing workforce through external appointments to senior positions and partial integration of nurse training within mainstream NHS. Even positive reviews of the high secure services were often tentative, as can be seen with the 1995 review of Ashworth by the NHS Health Advisory Service (HAS, 1995). Whilst noting areas of exemplary practice and the elimination of dehumanising practices at Ashworth (Dale et al, 1995), it was also reported by Fallon (1999) that the NHS Health Advisory Service review team had not been allowed access to two particularly damming internal investigation reports as part of their review. This ultimately led the chair of the 1995 NHS Health Advisory Service review team to comment that they may well have altered their opinion of progress at Ashworth had they been allowed access to these reports (Fallon, 1999).

It can be seen that the high secure hospitals are now faced with an unprecedented degree of scrutiny and accountability for practice. NHS integration has introduced performance monitoring, clinical audit, service governance, and key performance indicators previously only internally collected and disseminated. The use of seclusion is one such performance and benchmarked target. This benchmarking against other high secure services and mainstream NHS organisations has encouraged a drive to improve performance and effectiveness, with financial penalties and the withholding of funding becoming part of the realities of NHS affiliation. This integration into the NHS has clearly lessened the isolation of the high secure hospitals, allowing more open monitoring, inspection and examination.

However, external gaze and superficial inquiry can often fail to uncover the true nature of an organisation; the culture underpinning its delivery of care and the experiences of those who work or reside within it. Of particular research interest is whether the high secure hospitals of today have changed so radically from the dehumanising and degrading services of old? or whether they have merely become more politically astute and better at presenting a positive image of the services they provide?

It is certainly true that the high secure hospitals today openly advocate a more enlightened and patient centred approach to treatment and aim to eradicate

the expression and display of overt forms of coercion, punishment or abuse. However, surface gaze would fail to establish whether these traditional overt displays of coercive and punitive behaviours have simply been replaced by more subversive and overt methods of maintaining a culture of control and containment. Whilst the punitive may not be as evident, do the controlling structures that govern patient activity and judge acceptability and normality remain?

It is only through exploration of the culture, and experiences of those residing or working within such institutions that we can come to determine the degree to which the psycho-social processes that help staff and patients respond, adapt, and develop new roles within them continue to be present. For the purpose of this study this includes the role of seclusion and special observations in this process. These elements will be discussed in detail in the findings chapter.

1.7 Culture, power and control in the high secure services

The following section specifically focuses upon the culture that pervaded the high secure hospitals; a culture reminiscent of the 'total institutions' noted by Goffman (1961) and historically based upon power and control. Despite the culture within these services often being criticised (Blom-Cooper, 1992; Boynton, 1980; Fallon, 1997) they are important to understand if attempting to explore the experiences of both staff and patients working and residing in these institutions.

For the purpose of this study, culture is defined as the customs, values, ideals, philosophies, behaviours, influences and social processes held as important by the organisation itself and by those working or residing within. Not only those that are overtly recognised, sanctioned and reinforced, but also those that remain implicit and covert but often just as avidly valued. It is in exploring the cultural influences within such services that the significance of practices such as seclusion and special observations to the maintenance of cultural norms may become clearer.

The culture within the high secure system was noted by Mason (1995) in his descriptive review of seclusion in the Special Hospitals Mason (1995). This work explored various elements of the practice from an action research perspective. His

aims were to review the literature on seclusion, establish a statistical framework to describe its use, develop a database for frequency and duration, determine reasons for initiation and termination of episodes, examine patterns and levels of assessment, and develop an educational and organisational change strategy to reduce its use (Mason, 1995). In this study Mason described the traditional culture within the high secure hospitals, noting one of control and containment; a finding that mirrored those of previous public inquiries into high secure practice (Boynton, 1980; Blom-Cooper, 1992). Mason viewed the development of such a culture as inevitable given the close historical affiliations of these hospitals with penal culture, values and philosophies; the relatedness of the users of both services; and the managerial responsibilities, authority, and veto over discharge of some patients traditionally held by the Home Office. A situation which is little changed today with the Ministry of Justice retaining the power to discharge those patients detained under sections of the Mental Health Act (TSO, 2007).

The embedded nature of penal culture reflected this through nursing staff affiliation to the Prison Officers Association (POA); the dominant staff side association within the 'special hospitals' both historically and even today. Criticised for having a negative and obstructive attitude (Cohen, 1981), their influence upon the running of these hospitals led Boynton (1980) in his review of services at Rampton to note that the POA had filled a leadership vacuum within the hospital. Murphy (1987) further argued that the overly custodial and anti-therapeutic ethos of the special hospitals would not change until the POA was ousted from them. In an inquiry into the murder of a patient at Ashworth hospital, Rowe (1991) noted the refusal of the POA to participate in the inquiry proceedings, with Kaye & Franey (1998) highlighting how the POA traditionally dominated in terms of which practices were acceptable from both clinical and employment perspectives. Clinically this would be determined by threats to prioritise security, to "oppose all manner of changes" (Kaye & Franey, 1998, p99), and with respect to employment by maintaining a promotion policy of "dead man's shoes" (p99) which favoured existing staff over those from outside the hospitals.

The presence and influence of the POA was not only seen through affiliation to the organisation itself, however, but was also reinforced through the traditional wearing of prison officer uniforms, carrying of keys, and delegated responsibilities

for the day to day relational, procedural and physical security of the organisations. These were points noted by Kinsey (1998) when arguing that the POA affiliations of nurses within the special hospitals tended "to emphasise the custodial element of their role" (p76), and by Dick et al (1990) who observed how nursing staff in the special hospitals "are in the position of being responsible for custodial duties, including significant non-nursing custodial duties" (p3). These responsibilities for undertaking non-clinically related tasks illustrate the pressures for nursing staff working within forensic psychiatric environments to reconcile the roles of carer and custodian (Mason & Mercer, 1998; Mason, 2002; Larue et al, 2009).

It has been argued, however, that this responsibility for everyday security provided nursing staff with a power base within the high secure system above that enjoyed by nurses within the majority of other health care settings (Mason, 1995); a status he notes was maintained by the use of coercion and control. Mason (1995) viewed such control as central to the culture of the high secure hospitals, arguing its maintenance to be a result of societal expectations to be protected from what it considered to be the dangerousness of the mentally ill. He further suggested that within the special hospitals was the belief of nurses that with the right to detain came the right to control and discipline; noting that with this power came a degree of elitism and the perception that the special hospitals were indeed 'special' (Mason, 1995). As hospitals providing care for the most violent and disturbed an internal culture developed that saw the maintenance of this power and control as paramount, and the role of the nurse as integral to achieving this through the provision of controlling, and at times abusive and punitive interventions.

The staff exercise of control was not limited to patients, however. New nursing staff were expected to conform to the traditional norms and values held by the existing nursing staff. Mason (1995) likened this to the findings of Morrison (1990) in her observations of staff behaviour in general psychiatric units. She found cultural indoctrination to be a significant factor in the behaviour of staff, with social sanctions taken against those who failed to adopt accepted institutional norms. Mason (2005) himself noted how nursing staff new to high secure services would be inducted into the use of seclusion through the recounting of tales of "past 'great victories', 'battles' and 'disputes' in which violent patients were brought under control" (p43), with the telling of such stories told to the newcomers as "practising

rites that must be adhered to" (Mason, 2007, p24). He further notes how the responses of the new staff to the existing customs and practices of the ward would determine whether they were accepted as a member of the cultural staff group, or whether they remained an outsider; worthy of caution and observation (Mason, 2007).

Along with these internal pressures to conform and maintain control were the external expectations placed upon the special hospitals. Aside from their commissioned goals of providing treatment under conditions of maximum security and protection of the public came the role of providing care to patients whose conditions had failed to respond to conventional treatments. This often led to the hospitals being used as a means of disposal for extreme cases by the health, prison and criminal justice systems (Dick et al, 1990), with expectations that that these hospitals would manage and control the most difficult of patients. These internal and external influences encouraged staff to maintain order and control; to exert power and to discipline. They were powerful forces that impacted upon the treatment process on therapeutic, professional, ethical, moral and legal levels. They combined to create a relationship between overtly sanctioned and professed goals, ideals and values, with covert and implied customs, practices and behaviours based upon penal culture that was distinct within the health service. This point was illustrated by Charles Kaye, the then Chief Executive of the Special Hospitals Service Authority, in addressing the Inquiry into the Personality Disorder Unit at Ashworth hospital (Fallon, 1999, par.2.1.19) when noting that "The whole milieu, the whole ethos, is radically different from anything you are going to see in the Health Service. Until you accept that and take that as your base line for looking at special hospitals, what they do, what problems arise, you will not understand at all what is going on within those institutions."

This view that the high secure hospitals are in some way distinct from other psychiatric settings has been highlighted by Mason & Mercer (1998) when noting how the "values of custody, detention and imprisonment are interposed with those of care, consideration and compassion" (p2). Holmes (2002) highlighted this issue further when suggesting that staff were often faced with two contradictory directives; one of controlling and one of caring; to provide ethical care as a health care professional whilst at the same time protecting society and being a

correctional agent. These contradictory roles can give rise to ethical dilemmas for nurses at times (Gadow, 2003), with Kent-Wilkinson (1996) highlighting how positive attitudes can be difficult to maintain for nurses in a forensic environment as a result of derision over offending behaviours.

This potential conflict and tension between the custodial and therapeutic aspects of forensic psychiatry can also be seen to exist at an organisational level, with Kinsey (1998, p77) noting how "if either concept outweighs the other, it usually indicates that somewhere, somehow, the operation is out of kilter and becoming dysfunctional". High secure hospitals are tasked with not only improving the therapeutic ethos of the services provided, but also required to ensure the continuing safety and protection of the public; in essence the need to balance safety and security requirements of others with the therapeutic needs of those for whom they are providing care. These constructs were explicitly stated in the objectives given to the Special Hospitals Service Authority (SHSA) when formed in 1989; to ensure the continuing safety of the public and to ensure the provision of appropriate treatment for the patients (Kinsey, 1998).

Effective balance has proved as difficult to achieve for the special hospitals at this organisational level, however, as it has for the individual nursing staff working within them. Many of the major incidents and key events in the recent history of the hospitals have arisen as a result of tensions between custody and care, protection of the public and the rights of individual patients, and between the rights of patients to receive care and the protection of other patients. The continuing changing of priorities between security and therapy is perhaps understandable, however, when one notes the call for increased security after escapes and murders (Scottish Home & Health Department, 1977) and the concerns expressed over excessive liberalisation (Fallon, 1999) against a backdrop of calls for empowerment, therapy and patient focused care following findings of ill treatment and abuse (Boynton, 1980; Blom-Cooper, 1992). Irrespective of drivers towards security or therapy, what is clear is that real conflicts and dilemmas exist on both organisational and individual levels, and that history would suggest that at times the custodial element has dominated over the caring component on both levels.

The visible reminders and reinforcers of power and control remain as evident today in the high secure hospitals with the physical walls, bars, locks, and use of CCTV, through to the overt restrictions upon movement, egress and social access. The hospitals continue to reinforce these constructs and hold them as central tenets upon which practice is based. The safety and security directions (DoH, 1999 – revised 2011) serve as a constant reminder to the services of the need to maintain standards of security even at the expense of individualised care, with the service required to pass an annual inspection of adherence to security procedures to maintain their license to practice. It is of note that there is no annual inspection of clinical practice.

Having a high secure psychiatric system with a structure and culture based upon power and control, however, does not prove surprising in or of itself, particularly in light of the historical development and traditional affiliations with the penal system described earlier. Indeed one of the externally prescribed primary functions of these services is an overriding requirement to maintain public safety through the enforced detention of its patients. Historically, however, criticism has been focused not as much upon the ideals of containment and control, but more in the way in which it has been exercised within a culture of punishment, degradation and abuse. Of research interest, therefore is the degree to which these traditional shows of organisational strength and power continue in contemporary practice or whether different and changing forms and methods are used in the maintenance of control.

There are many ways in which power and control can be overtly exerted within psychiatric environments, ranging from the physical elements of walls or locked doors and barred windows, through to the controlling aspects of administering psycho-tropic medication, or even by the physical force and presence of staff themselves (Bowers et al, 2012; Mason & Chandley, 1998). It has been seen that in high secure care the use of highly restrictive and invasive interventions such as physical restraint, seclusion, and special observations have been traditionally used to enforce the will of staff, ensure compliance and maintain an imbalance of power (Mason, 1995). Yet the exercising of power need not always be as overt. Holmes & Gastaldo (2002) talk of influence and note how this

can be exerted effectively upon patients in subtle and non-physical ways; ways that are often seen as more acceptable than the use of physical force (Lutzen, 1998)

In a system where a primary function is seen as the management of an involuntary population there will inevitably be a requirement for a degree of structure to maintain control and order. However, in the exercising of this power and control one has to remain mindful of the motives for disciplinary action; a point noted by Gentilin (1987, p14) when highlighting that "there are occasions when people, in order to rationalise passive-aggressive impulses, will couch disciplinary measures in terms of the patient's own best interests". It is in the motivations and rationalisations driving the imposition of these restrictions that can determine whether the use of power and control is required and justified, or whether their use is held to be abusive and lacking in therapeutic necessity.

This potential to discipline in the name of therapy is important to note as it is through exploration of practices such as seclusion and special observations that we will come to uncover how staff appreciate, articulate and internalise the controlling elements and requirements of their role, and how we can come to appreciate how they rationalise and justify their practice and behaviour to themselves and others. It is through this that we can come to learn how staff come to reconcile the emotional conflicts noted by Goffman (1961) when faced with the competing demands of enforcing organisational obligations whilst acting in the patient's best interests through the use of restrictive practices.

From what we know about the development of the high secure hospitals various types of power have been traditionally used to maintain control and order. Perhaps the most readily observable and recognisable form has been in the physical displays of force and control. Goffman (1961) described how the physical security of 'total institutions' would often serve as visual reminders to patients of their status and worth; reinforcing their disempowerment and disenfranchise. Mason (1995) noted how power has been historically exercised through the use of punishments and rewards including such practices as seclusion, special observations and enforced medication to mould behaviour and maintain compliance and dominance. These, again reminiscent of 'total institutions', were often highly visible and on occasion used as deterrents for rule breaking.

This notion of visibility was significant to Goffman (1961) who noted the significance of outward displays of reinforcing social status and power relations. In the high secure hospitals this was particularly evident with the use of seclusion rooms. Here their presence would often be within the main ward communal areas and would be marked by piles of clothing placed outside to signify an occupied room. This would serve to reinforce to patients what Malacrida (2005, p528) highlighted as the need for the unruly to be "contained, isolated and broken". Malacrida (2005) also talks of how the public use of seclusion and special observations can be likened to public spectacles, warning patients of potential consequences of transgressions; "a visual performance of institutional might" (p532). This concept of exercising control through visible emphasis of the power imbalance was traditionally reinforced further within high secure hospitals by the use of staff uniforms, and whilst no longer in use, there remain a number of other visual reminders and symbols of institutional power. These include the carrying of keys, the regular counting of patients, the omnipresent observation of patient areas, and the use of UHF radios to serve as constant reminders to patients of their subservient role, disempowerment and disenfranchise.

Yet the use of overtly visual shows of physical or environmental power and strength were not the only method of control used within the high secure hospitals. It can be seen how the use of the organisational routines noted by Goffman (1961) played a significant part in the maintenance of discipline and control to maintain compliance and encourage docility. These traditionally included the searching of patients and their possessions, screening of urine for illicit substances, monitoring of mail and telephone calls, and undertaking of head counts. These routines offered a more subtle form of regulation in that a degree of self regulation was used to ensure compliance; patients never knew when they may have been observed, monitored, searched or counted. Lakritz (2009) likened this use of power to providing an Orwellian 'big brother' approach to maintaining control, and whilst less overtly punitive in nature, assisted in reinforcing the dominance of staff and the organisation over patients. Of note here is the view from Holmes & Gastaldo (2002) that such power does not require violence to be effective and is characterised by surveillance, observation, penalties and rewards; all approaches traditionally used in 'total institutions' such as high secure hospitals to a degree above and beyond that used in many other clinical settings.

Whilst these types of exercising control remain very much in evidence in contemporary high secure practice, the use of care planning, case reviews, risk assessments and the levels of observation used within general health care settings has also been noted as a means of reinforcing the patient role and maintaining influence and control (Malacrida, 2005). This was described by as the use of indiscreet hierarchical observation (Bradbury-Jones et al, 2007). Within high secure hospitals these forms of power relations can present as particularly significant to patients who often hold them as important markers in their pathway out of hospital, and influential in determining identity and status within both the organisation and peer groups. An example of this can be seen in the provision of 'grounds access' whereby a select group of patients within the high secure system are allowed wider access to hospital grounds at particular times. Whilst under the potential gaze of CCTV and staff observation, these patients are afforded freedom of movement above and beyond that of the majority. This increased freedom helps to make 'grounds access' a highly desirable goal; a goal only obtained through behavioural compliance and positive case reviews and risk assessments.

This concept of patients seeking privileges and higher social status was noted by Goffman (1961), who described how patients who are compliant can avoid punishment and stigma, and subsequently progress through a health care system. This desirable outcome can raise esteem and elevate the patient within the hierarchy of his peer group. Goffman (1961) also noted that whilst often desirable for the individual, such stratifications within peer groups can have the potential to turn the oppressed into the oppressor. This provided patients with newly acquired control with the ability and opportunity to exert control over others who they perceive to be lower in the hierarchical structure of the group.

A further important form of power noted by Goffman (1961), in his description of staff culture in 'total institutions', was that of use of information. This is the power obtained by one person over another as a result of knowledge about the individual and the subsequent ability to influence and mould that person's behaviour. Goffmanv (1961) noted how staff would often use patients' previous behaviours and recorded histories as a means of judging, reinforcing social status, modifying behaviour and maintaining the power imbalance. Within the high secure hospitals this traditionally been used to justify both individual and organisational

action and behaviour, and help contribute to what Goffman (1961) describes as being part of the staff culture to rationalise patient behaviours to reconcile conflict.

Part Three: Seclusion and Special Observations

1.8 Introduction to seclusion and special observations

This part of the chapter will discuss the approaches of seclusion and special observations; not only with respect to their use in high secure services, but also within mainstream psychiatric practice where relevant. It will highlight both the controversial and complex nature of these interventions: noting the rationales and justifications offered by those supporting its use, and the concerns and contra-indications forwarded by those critical of their use. It will continue by illustrating the diversity of literature available on the use of seclusion, and highlight, by comparison the relative paucity of that available for the use of special observations.

It will examine the literature on the perceptions, feelings, opinions, values or experiences of staff and patients to seclusion or special observations, and draw on the literature on their use in high secure services. Finally it discusses the issue of potential overlap in practice between the two practices at the research site.

1.9 Seclusion

In U.K. seclusion is defined in the Code of Practice to the amended Mental Health Act 1983 (DoH, 2008) which holds it to be "the supervised confinement of a patient in a room, which may be locked, to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others" (DoH, 2008, ch15.43, p122). Whilst this is the definition governing its use at the research site, definitions of seclusion often differ in the literature.

Mason (1992) noted how whilst varying definitions would often make reference to space, reason, social isolation, being confined, force and duration, there did not appear to be a universally held definition covering all aspects of the practice. He highlighted how some authors would emphasise the social element of being forcibly isolated from peers and social networks, others the temporal element of the time confined, some the inability to egress from the confinement of a locked room through free well, and others still the emphasis upon the use of a designated room (Mason, 1995). What appears characteristic of many of these definitions, however, is the lack of theoretical constructs underpinning or driving its use;

whether seclusion is considered by these authors to be a containing or treatment strategy.

It is also noted that at times definitions of practice can appear culturally dependent and on occasion a result of researchers either adopting different definitional criteria (Mason, 1995) or even failing to offer any definition of practice at all. In their review of the literature on seclusion Lendemeijer & Shortridge-Baggett (1997, p300) highlighted how "little or no attention is paid to the definition of the concept" and how it would appear that "authors assume that the meaning of the term is evident" (p300). It is also noted that variations in practice and consideration of what constitutes seclusion can vary even within individual health care systems that use the same definition; a point illustrated by the Department of Health when widening its definition of seclusion in its Code of Practice to the amended Mental Health Act 1983 (DoH, 2008) to incorporate other isolative practices that had previously not been classified as such.

Whilst this U.K. definition offers a rationale for the use of seclusion; namely the protection of others, it fails to acknowledge or make reference to either potential therapeutic benefits or adverse effects upon the patient that may be either desired or likely to occur. As such, the definition maintains its consideration of seclusion as being a containing rather than therapeutic strategy; a point previously highlighted by Exworthy et al (2001) and worthy of note when considering potential or expected outcomes of seclusion. This view of seclusion as a short term approach to the management of violence and aggression is of particular relevance to the use of seclusion within the high secure services, where durations of episodes often extend beyond the immediacy and often last for extended periods; sometimes weeks, months or even years. Whilst historically the length of such regimes would appear to have been at odds with the U.K. definition of seclusion which allows the use of seclusion only for 'severely disturbed behaviour', the amended Code of Practice (DoH, 2008) formally recognised the long term risks of violence with some patients, largely in the high secure estate. For this small group of patients, for whom short periods of seclusion would be unlikely to alleviate the risks to others, the amended Code of Practice (DoH, 2008) now provide for the longer-term segregation of this group. From a practice perspective these longer-term segregation regimes mirror those of seclusion, with the patients subject to the

same restrictions, safeguards, monitoring and review. For the purpose of this study there will be no distinction made between the use of seclusion and the use of longer-term segregation. This is due to the only distinguishing characteristics between the two being the duration of the regime itself. Patients in seclusion are considered as being longer-term segregated once the seclusion regime reaches day 15. This is an externally directed transition..

1.10 The seclusion debate

This part of the chapter will highlight the arguments expressed by both those who support and oppose the use of seclusion. It notes how at times seclusion has the tendency to polarise opinion and will illustrate how those advocating its use consider it to have either containing or therapeutic value, and those opposing its use holding it as punitive, damaging and without therapeutic merit. It will identify the arguments forwarded on both sides of what can at times be considered to be a protagonist-antagonist debate.

It is in examining these arguments and the constructs on which they are based that allows us to appreciate the complexities of seclusion; one of the most provocative and controversial approaches in mental health nursing (Morrison & Le Roux, 1997). This linking of arguments to theoretical constructs plays an important role in the literature on seclusion, often used as validating evidence by those supporting its use, and yet criticised by others who argue that they not only fail to be underpinned by research (Finke, 2001) but also arise from perspectives that fall short of sound theory (Mohr, 1997). It is in the arguments forwarded by both the protagonists and antagonists of the practice that the often emotive nature of seclusion can be seen; with both proponents and opponents expressing opinion and judgement over its use in clinical, academic and legal arenas.

Of interest in this debate, however, is the point raised by Alty & Mason (1994) when they noted that many proponents of seclusion will cite theoretical constructs to argue their point, whilst many of those who oppose seclusion will use moral arguments or anecdotal evidence and personal opinion; largely basing their objections on ethical grounds (Terpstra et al, 2001). Lendemeijer & Shortridge-Baggett (1997) further argue that when seclusion is forwarded as having therapeutic benefits authors are often less clear as to whether this relates to the

room itself, the act of removing the patient, or of the activities and input offered the patient whilst in seclusion.

The arguments forwarded by those on both sides of this protagonist-antagonist debate have been discussed in the literature at length and are often cited in the many literature reviews on the use of seclusion (Brown & Tooke, 1992; Fisher, 1994; Alty & Mason, 1994; Lendemeijer & Shortridge-Baggett, 1997; Sailas & Fenton, 2000; Busch & Shore, 2000; van der Merwe et al, 2009). These authors have attempted to adopt a neutral stance in their examination of seclusion and sought to consolidate knowledge and understanding through systematic reviews of the literature; allowing for improved understanding and classification of themes and grouping of issues.

These existing literature reviews demonstrate the substantial research undertaken on the use of seclusion and illustrate the range of elements focused upon. These include such diverse issues as reasons for use; indications and contra-indications; staff factors such as training, experience, levels, and attitudes; prevalence rates; patient typologies and clinical variables; environmental factors; impact and outcomes; duration; effects upon both staff and patients; policy and guidance; moral, ethical and legal concerns; and even such issues as seasonal variation and lunar phases. A summary of the focus of these literature reviews and findings can be seen below in Table 2.

The protagonist arguments in the literature are largely based upon the belief that seclusion holds some therapeutic value or benefit. This may be to the patient themselves (Gutheil, 1978; Gair, 1980; Royal College of Psychiatrists, 1982; Grigson, 1984; Cotton, 1989), in the protection of others (Tardiff, 1992; Fisher, 1994; Alty & Mason, 1994), or in the safeguarding of the ward milieu or environment (Nijman et al, 1999; Lendemeijer, 2000). It has also been argued that it may be of use in the prevention of property damage (Gutheil & Tardiff, 1984; Ahmed & Lepnurm, 2001).

Authors (Year)	Focus / Findings
Brown & Tooke (1992)	The authors reviewed the literature on seclusion and found that it was more often used for agitation than violence. They found that at times seclusion would be used to manage the challenges of the ward rather than the behaviour or presentation of the patient. They noted that there was a tendency to seclude on admission and that psychotic, detained, and younger patients were more likely to be secluded. They found no significant differences by age or ethnicity, but noted that incidence and duration differing greatly. They noted a disparity between views of pts (negative) and staff (more positive), with patients often feeling angry, depressed and punished. They also noted a lack of systematic studies into its use.
Fisher (1994)	The author grouped his review into indications & contra-indications, demographic information, clinical & environmental factors, the effects on patients & staff, and implementation & training. The author found that indications included prevention of injury to others, to prevent damage to property, prevent disruption to treatment programme, protection of ward milieu, use in behaviour therapy and to reduce stimulation and agitation. He found that it should be contra-indicated as a substitute for treatment, as a punishment, for staff convenience, as a result of non-compliant behaviour, or when seen by a patient as a positive reinforcer. He found it can have negative physical and psychological effects on both patients and staff, and that rates can be influenced by both clinical and non-clinical factors. Found that seclusion could prevent injury and reduce agitation, and that the majority of clinical environments could not operate without seclusion. He also found that staff training in predicting violence, de-escalation, and restraint could reduce use. Also, that both clinical and non-clinical factors (such as cultural bias, staff perceptions and organisational culture) could influence the rate of use.
Alty & Mason (1994)	This review looked at facts, statistics & research findings, theory & interpretations, methods & procedures, opinion, beliefs & points of view, and anecdotes, clinical impression & narrations. They found that arguments in the literature, used as a rationale for the use of seclusion, to be broadly grouped as either therapeutic, containing, or punishing. They found little evidence to support therapeutic value and considered seclusion to be ethically controversial. They argued that there was evidence that at times it was used as a sanction against rule breakers and used as a means of maintaining order, compliance and control within the ward environment. They noted a wide variation in use across services and countries, and found non-clinical contextual factors to play an important role in determining use. This included staffing levels, and experience, and ward and organisational culture They found negative patient experiences, with anger being the main consequence..
Lendemeijer & Shortridge-Baggett (1997)	This review looked at definitions, concepts, patient and hospital characteristics, motives for use, and experience of patients. They noted a lack of universally accepted definition. They also considered evidence in the literature that seclusion could be effective in managing potentially dangerous behaviours, and whilst not therapeutic in itself, believed it could create an opportunity for therapeutic engagement. They found that its use can be influenced by both clinical and non-clinical factors, and noted that relatively few studies have focused on patient experience. They found most patient experience studies to highlight negative emotional experiences. They noted that demographic data is inconsistent within the literature, with age being relatively consistent, but gender and ethnicity being more inconsistently reported. Non clinical factors influencing use included culture, staff attitude and the education of staff and managers.
Sailas & Fenton (2000)	The objective of this review was to review the literature to ascertain effects of seclusion against other alternative interventions, and against 'standard care'. They noted a complete lack of trial-derived evidence regarding the assessment of the impact of seclusion in severe mental illness, and a lack of controlled studies to evaluate the usefulness or side effects of seclusion. They argued that its use should be minimised for ethical reasons given the reports of harm in the literature and that trials assessing the effects is required.
Busch & Shore (2000)	This review looked at rates, duration, and methods of seclusion. They found these to vary widely and noted there was little evidence available to guide clinical practice. They considered that further efficacy and effectiveness studies were needed, and highlighted that various programmes exist that have successfully reduced use of seclusion. They found inconsistent staff decision making based on gender, educational level and clinical experience.
Sailas & Wahlbeck, (2005)	The review looked at policy and guidelines, and considered prevalence (multi-national – including ethnicity), cultural values, and reduction initiatives. They found that there is a need for novel methods to treat violence and the threat of violence and that this needs a multi-professional approach. They argued that patient involvement in this would be important. They also noted that the assessment of the effectiveness of programmes aimed at minimising the use of seclusion had been hampered by a lack of parallel control groups and that there was a need for cluster-randomised trials.
van der Merwe et al, (2009)	This review looked at seclusion from a multi-national perspective and looked at prevalence, duration, environment, location, antecedents, reasons for use, and staff and patient attitudes. They also looked at patient clinical and demographic profiles and associated interventions. Key findings included different rates between countries, with UK and USA having highest event-based seclusion rates, and whilst noting fewer episodes in forensic settings, they found these to be of longer duration. They also found that patients who had been secluded had an increased length of stay, and that episodes also noted to be longer at night and at weekends and holidays. Secluded patients tended to be younger than non secluded patients, and more likely to be legally detained. They noted that in the UK BME groups were more likely to be secluded than non BME groups, and that seclusion was most often used in the management of aggression. They found that lower levels of staff experience and education could increase use of seclusion, with higher staffing levels leading to less seclusion. They also found that seclusion made patients feel angry, lonely, sad and hopeless, punished and vulnerable.

Table 2: Summary of findings/focus of literature reviews on the use of seclusion

Stated patient benefits include the propensity to reduce agitation and sensory stimuli (Gutheil, 1978), imposing of external control and structure (Fisher, 1994; Heyman, 1987), and opportunity for maturation and growth (Grigson, 1984). Arguments have also been forwarded supporting its use as providing opportunity for therapeutic engagement (Richardson, 1987; Alty & Mason, 1994), and as a containment strategy (Gutheil, 1978; Outlaw & Lowery, 1992; Fisher, 1994; Mason, 1993; Alty & Mason, 1994; Walsh & Randell, 1995).

However, these views supporting seclusion as having therapeutic benefit are often criticised for lacking theoretical grounding or systematic controlled evaluation (Brown & Tooke, 1992; Sailas & Fenton, 2000), for lacking proof of therapeutic rationale (Muir-Cochrane, 1998), and for failing to add to the therapeutic goal (Finke, 2001). It has also been argued that seclusion lacks established efficacy with respects to patient welfare (Donat, 2002; Larue et al, 2009), and that the arguments forwarded by its supporters even fail to adequately describe how effectiveness or ineffectiveness is measured (Griffiths, 2001). Despite these criticisms, however, seclusion remains an accepted intervention in the management of disturbed patients. Indeed LeGris et al (1999) argue that it not only remains accepted but is often the intervention of choice in many settings.

One of the most significant arguments forwarded by those critical of the continuing use of seclusion are the negative effects upon patients reported in many research studies. Authors have argued that seclusion is both punitive (Topping Morris, 1992; SHSA, 1992) and damaging (Wadeson & Carpenter, 1976; Grassian & Friedman, 1986; Orr & Morgan, 1995). Others have further argued that it conflicts with the principle of beneficence (Colaizzi, 2005) and that the use of seclusion can be seen as being in conflict with the principles of holism, humanism and client-centred care (Le Gris et al, 1999).

There is evidence from public inquiry reports that suggest seclusion has been used to punish within psychiatric services (Boynton, 1980; Blom-Cooper, 1992; Prins, 1993); a point noted by Foucault (1967, p269) when stating that "madness will be punished in the asylum, even if it is innocent outside of it". Here Foucault forwards the argument that transgressions from not only societal but even institutional norms can result in punitive measures against the mentally ill.

Perceptions of punishment are certainly present in the literature on seclusion, (Binder & McCoy, 1983; Soliday, 1985; Heyman, 1987; Brown & Tooke, 1992; Fisher, 1994; LeGris et al, 1999; Martinez et al, 1999; Meehan et al, 2000; Ntsaba & Havenga, 2007; El-Badri & Mellsop, 2008; Roberts et al, 2009; Keski-Valkama et al, 2010).

Whilst there is little support for the punishment of patients it is noted that arguments have also been forwarded that on occasion punishment may be used as a means of behaviour modification within behavioural treatment programmes (Tardiff, 1984). Alty & Mason (1994) further noted that seclusion has on occasion been used as a sanction against institutional rules and that an element of punishment is to control and discipline. It is clear that the concept of punishment is noteworthy when exploring the practice of seclusion and is closely related to the concepts of control and discipline.

1.11 Staff and patient experiences

Whilst the body of literature on the use of seclusion is diverse, and covers many aspects of the practice, there is a relative paucity on the examination and exploration of either staff or patient experiences, both in general but particularly in forensic settings. This provides limited opportunity to explore the effects of the practice upon those implementing it and those subject to it, or indeed to examine the relationship between the practice to the pervading organisational cultures within clinical environments.

This lack of focus on staff and patient experiences was noted by VanDerNagel et al (2009, p409) when highlighting how "few studies have looked into the perception of seclusion by nurses", by Holmes et al (2004, p599) when highlighting that "few studies have examined the experience of patients being confined", by Keski-Valkama et al (2010, p447) when noting that "the knowledge of the secluded forensic patients' views is sparse", and by Haw et al (2011, p566) when noting that "much of the literature on coercive treatments has been conducted in acute psychiatric units or on outpatients attending mental health centres". These reinforce the point previously forwarded by Alty & Mason (1994, p161) when they professed that "throughout the available research papers it is underlined that nurses often do not perceive how a patient feels when placed in

seclusion", and serve to reinforce the importance of further study in these areas of seclusion practice. With respect to high secure services it has been argued that the use of seclusion has traditionally played an integral role in the maintenance of a culture of control and compliance (Mason, 1995)

To review the literature on the experiences of staff or patients, an electronic database search of AMED, BNI, CINAHL, PsychINFO, Cochrane Library, ebrary, Intute, MEDLINE, ProQuest, Scopus, Web of Knowledge and Wiley Interscience, for the terms seclus* or isola*, and experien* or attitude* or percept* was undertaken. This search highlighted that whilst some studies noted the experiences, attitudes or perceptions of staff or patients, these were often not the primary focus of the study, and as such often only contributed to peripheral findings.

Of those studies identified as relevant, some focused on the patient experience (Wadeson & Carpenter, 1976; Binder & McCoy, 1983; Richardson, 1987; Mann et al, 1993; Martinez et al, 1999; Meehan et al, 2000; Palazzolo, 2004, Hoekstra et al, 2004; Keski-Valkama et al, 2010), some on the staff experience (Klinge, 1994; Wynn, 2003; VanDerNagel et al, 2009) and others on both (Plutchik et al, 1978, Soliday, 1985; Heyman, 1987; Petti et al, 2001; Meehan et al, 2004; El-Badri & Mellsop, 2008).

Pannu & Milne (2008) and Keski-Valkama et al (2010) specifically highlight the dearth of literature available on the perceptions of staff of patients to seclusion within a forensic environment. This is considered to be of particular significance for this study given the distinctions between high secure and general psychiatric settings. Distinctions that were highlighted earlier in the chapter when discussing the nature of UK high secure care and included the legal and social influences prevalent within such settings. These included the long standing affiliations with penal institutions (Mason, 1995), the brutal and damaging regimes (Blom-Cooper, 1992), the culture of containment and control (Mason, 1995), and the professional and ideological isolation that high secure services have historically experienced (Rowden, 2000) and which have helped influence and shape seclusion practice within these forensic settings.

A similar electronic database search of AMED, BNI, CINAHL, PsychINFO, Cochrane Library, ebrary, Intute, MEDLINE, ProQuest, Scopus, Web of Knowledge and Wiley Interscience, for the terms seclus* or isola* and secur* or forensi* was used to identify studies focusing on the use of seclusion within forensic setting. Existing literature within forensic settings has largely focused upon prevalence, trends, duration and patient characteristics (Heilbrum et al,1995; Mason, 1995; Ahmed & Lepnurm, 2001; Beck et al, 2008; Pannu & Milne, 2008; Thomas et al, 2009); environmental factors (Daffern et al, 2004); or differences between ethnic groups (Price et al, 2004). Further attention has been focused upon analysis or description of reduction programmes (Goodness & Renfro, 2002; Fisher, 2003; Qurashi et al, 2009; Ching et al, 2010), medical views on whether considered punitive or protective (Exworthy et al, 2001), policy issues (Cormac, 2005) and relationships to privacy (Stolker et al, 2006). Studies have even looked at relationships to physical conditions such as cholesterol or lipid levels (Repo-Tiihonen et al, 2002; Paavola et al, 2002). Few studies, however, have focused primarily upon the experiences of the patients subjected to seclusion within forensic populations (Keski-Valkama et al, 2010) or the staff involved in its implementation.

From the existing literature it is evident that there are limited studies that have primarily focused upon the perceptions or experiences of staff or patients to the use of seclusion, with those undertaken being with non-forensic staff and patient populations. It is noted, however, that a number of research studies have identified elements of patient experiences as part of a broader exploration of seclusion practice; giving a limited degree of insight into the feelings and emotions often experienced. It is in light of this limited knowledge that the exploration of the views and experiences of staff and patients presents as so worthy of further research. This is of particular interest in forensic populations where the duration of seclusion regimes can last significantly longer than in general psychiatric practice, and are implemented within the context of a highly structured, controlling and disenfranchising environment for patients.

As noted earlier, the most common patient perception of seclusion noted in the literature is that of punishment (Binder & McCoy, 1983; Soliday, 1985; Heyman, 1987; Brown & Tooke, 1992; Fisher, 1994; LeGris et al, 1999; Martinez et

al, 1999; Meehan et al, 2000; Ntsaba & Havenga, 2007; El-Badri & Mellsop, 2008; Roberts et al, 2009; Keski-Valkama et al, 2010) This is a complex issue enmeshed with the concepts of social control, conformity and discipline; points considered by Fennell (1996) when highlighting the difficulty in unravelling the potentially punitive or protective elements of seclusion and Gostin (1986) in recognising that at times it is difficult to differentiate between acceptable discipline and unacceptable punishment.

Other feelings reported by patients in the literature have consistently proved negative. These have included anger, fear, helplessness, loneliness, frustration, humiliation and resentment (Wadeson & Carpenter, 1976; Binder & McCoy, 1983; Soliday, 1985; Norris & Kennedy, 1992; Martinez et al, 1999; Meehan et al, 2000; El-Badri & Mellsop, 2008; Roberts et al, 2009; Keski-Valkama et al, 2010), with some studies even noting distress, agitation and trauma (Martinez et al, 1999; Hoekstra et al; 2004; Frueh et al, 2005; Roberts et al, 2009). It is clear in the literature on seclusion that the majority of patients experience it negatively, with positive reports noted in these studies usually expressed from a minority of patients and generally relating to peace, quiet, ability to sleep, and opportunity to calm down. Several of the studies are of particular note with respects to patient perceptions, however; notably those from Hoeskstra et al (2004), Meehan et al, (2004), El-Badri & Mellsop (2008), Roberts et al (2009, and Keski-Valkama et al (2010).

Hoeskstra et al (2004) focused their study upon patient perceptions of seclusion by understanding long-term views and effects upon staff-patient relationships. Interviews were undertaken with patients following discharge to ascertain perceptions of previous seclusion episodes and subsequent relationships with staff. Findings from this study indicated a largely negative experience for patients, although some patients for whom the episode occurred a significant period earlier did express some positive elements such as peace and safety. Of particular interest from this study were the negative experiences focusing upon perceptions of inequitable treatment, potential for reoccurrence, and issues of trust in their relationships with staff resulting from the daily threat of further seclusion.

The study by Meehan et al (2004) is often cited in the literature. A survey based study of both staff and patient attitudes towards seclusion was undertaken in acute units, with significant findings including the patient perception that seclusion may be used for non-compliance, attempts at absconding and refusal to take medication. Whilst the majority of patients failed to view seclusion as therapeutic, some did acknowledge that it could help them calm down. A further study El-Badri & Mellsop (2008) undertook a questionnaire based study in a general psychiatric unit to ascertain the perceptions of both staff and patients. Patients in this study viewed seclusion as controlling, punitive and over used. They felt that alternative approaches were not considered often enough and that the episode gave rise to feelings of fear, anxiety and loneliness. They reported feeling powerless, angry and mistreated, with some claiming a worsening of psychotic symptoms and a lack of communication with staff during the episode. As with many studies, a few positive benefits were reported including feelings of relief and opportunity to sleep.

Roberts et al (2009) used a mixed approach to identify staff and patient views on the use of seclusion. Patient perceptions included feelings of trauma, anger, annoyance, and of being trapped. Of particular significance was the patient view that seclusion was used too readily and fot too long, that communication with staff during the process was poor, and that staff were too ready to use physical restraint during the implementation of seclusion. A recent study by Keski-Valkama et al (2010) looked at patient perceptions of seclusion by comparing forensic and non-forensic populations by way of initial and subsequent follow-up interviews some 6 months later. Both forensic and non-forensic groups considered seclusion as negative and punitive, and expressed concern over level of interactions with staff during the episode. Two issues from the findings are of note from this study. First is the issue that the perception of punishment was significantly higher in the forensic cohort, and second that the mean duration of seclusion episodes were longer in the forensic sample.

This issue of duration is considered to be of particular importance to this study. Mason (1995) argues that aside from the decision of whether to use seclusion or not, the issue of duration is the most contentious issue associated with the use of seclusion. Existing literature suggests that the mean duration of seclusion episodes are greater in forensic settings than other psychiatric setting. In

their review of the literature on the use of seclusion, Lendemeijer & Shortridge-Baggett (1997) compared the published data from a number of studies on the use of seclusion and found a mean duration of between 2.5hrs and 25.6hrs per episode within non-forensic settings. An earlier study by Tooke & Brown (1992), however, found a mean of around 50 hours per episode, although a more recent review of the literature (van der Merwe et al, 2009) found U.K. mean duration rates of 2.85 hours for UK non-forensic populations and 21 hours for U.K. forensic populations.

In comparison Mason (1995) found a mean duration of forensic male patients in one U.K. high secure hospital of 82.8 hours, Ahmed & Lepnurm (2001) a mean of 90.3 hours from a forensic population, and the highlighted study by Keski-Valkama et al (2010) a mean duration from their forensic sample of 174.5 hours. Whilst further comparison between sample groups for matching of patient typologies, and clinical and demographic characteristics would need to be established, there is certainly evidence to support the view that seclusion within forensic settings can last longer than that in other settings. At the research site the mean duration of seclusion episodes in 2012 was 426 hrs; a figure clearly greater than the findings of van der Merwe (2009)

It is in light of the extended duration of seclusion regimes at the research site that potential effects upon both staff and patients will be explored. The potential psycho-social effects of long term confinement within a highly controlling environment may well prove different to those experienced by patients within a general psychiatric setting. Similarly for staff, the inmpostion of such long term regimes as a means of maintaining the controlling culture may prove a difference experience to staff implementing a short term seclusion regime within a general psychiatric setting,.

From a staff perspective, a study of staff perceptions undertaken by Wynn (2003) adopted a questionnaire-based design to explore the experiences and attitudes of staff to the use of seclusion (and restraint) within a large Norwegian hospital. Of note from this study was that the majority of staff considered the use of seclusion as beneficial in calming the patient, that many considered the use of seclusion as violating patient integrity, and that it had the potential to damage

relationships with patients. Of particular interest was the finding that staff considered the use of seclusion as potentially frightening to other patients.

The study previously highlighted by Meehan et al (2004) also looked at staff perceptions and found that many considered seclusion beneficial, with the majority considering it as being highly therapeutic. Few found it punitive, with the majority considering it to have positive and calming effects on patients. There was a significant support for its continuation, with staff claiming no feelings of power or guilt associated with its use. In contrast, however, the study by El-Badri & Mellsop (2008) found that staff would often feel frustrated, disappointed, and disgusted with the use of seclusion; considering it to be a betrayal of the patient. In noting this, however, the respondents also held seclusion as necessary, beneficial, and an opportunity for patients to calm down and allow for medication to work. Whilst feeing safer and relieved at times, staff also expressed feelings of fear and threat at the time of initiation of seclusion. Interestingly staff respondents considered that seclusion was used too often and for too long, and similar to the patients in the same study considered a lack of communication between staff and patient during the seclusion episode to be problematic.

In the study highlighted earlier by Roberts et al (2009) staff views included the consideration of seclusion as positive for patients and non-punitive. However, they would also often feel regret and disappointment at having to use what they acknowledged to be such a coercive measure. This view was supported in a study by Moran et al (2009) who also found that staff experienced emotional distress on the implementation of seclusion; often giving rise to feelings of anxiety, unease, fear and guilt. VanDerNagel et al (2009) interviewed staff on their perceptions of seclusion in a general psychiatric setting and found staff perceptions of fear for safety on the initiation of seclusion when faced with imminent patient violence. Of particular interest here was the finding that staff considered seclusion inhumane, shameful and degrading, giving rise to feelings of distress and pity.

In summary, therefore, it can be seen that despite the vast body of literature on the use of seclusion there still remains a relative lack of studies that have focused on exploring and examining the staff or patient experience, with even fewer focusing upon such issues in forensic settings. Whilst Haw et al (2011)

looked at patient experiences of coercive measures in a medium secure U.K. setting, and indeed noted that 16% of patients considered seclusion to have been beneficial to them, the main body of evidence from the literature clearly indicates that seclusion is largely negative experience for patients, with few therapeutic benefits noted. The literature reports that patients often experience heightened negative emotions of fear, helplessness, anger, humiliation and lack of control. Punishment appears a common theme in the literature on patient experiences of seclusion.

Alternatively, however, staff would often view seclusion as necessary; with Happell & Harrow (2010), in their review of literature on staff perceptions, noting that that majority of nurses consider seclusion to be important in the promotion of patient well-being and for maintaining safety. The literature suggests that staff often consider seclusion as therapeutic, or at least beneficial in allowing patients to calm and to provide time for medication to work. Staff feelings around the use of seclusion appeared to vary, however. Whilst some staff expressed little concern over the use of coercive measures such as seclusion, whilst others have been reported as experiencing significant negative emotions and concerns that include feelings of guilt, distress, regret and disappointment. Of note, however, is that the majority of these studies were undertaken with non-forensic staff populations.

1.12 Special Observations

As with the use of seclusion, the literature does not appear to hold a common definition for special observations, although there are clearly common elements based upon the allocation of a nurse or other health worker to supervise a patient at periodic intervals above and beyond the levels assigned to other patients. Whilst Bowers et al (2000) highlighted how local policies and terminology can differ significantly, the introduction of the NICE Guidance for the short-term management of disturbed/violent behaviour (NICE, 2005) ultimately provided the U.K. with a clear definition and recommendations based on common terminology.

At the research site the policy governing its use (Mersey Care NHS Trust, 2010) reflects the definition provided by NICE (2005) and adopts its terminology and practice standards. These include the assignment of a health care worker, usually a nurse, to support, supervise and engage with a patient who may require

increased levels of observations as a result of mental state or clinical presentation. Levels of observations are as those identified by NICE (2005) which include general (those normally assigned to patients), intermittent (periodic checks), within eyesight (constant observations) and within arm's length (constant and within close proximity). For the purpose of this study the practice of special observations are taken to mean those levels either within eyesight or within arm's length.

Traditionally used for the management of patients presenting with self injurious or suicidal intentions or propensities within many psychiatric settings, the use of enhanced levels of observation or supervision of patients is becoming an increasingly common intervention in the management of patients presenting as disturbed and potentially violent within a variety of clinical settings (Bowers et al, 2000; Jones et al, 2000; Neilson & Brennan, 2001; Mackay et al, 2005; Whitehead & Mason, 2006). In noting this, however, it is recognised that in high secure services this use of enhanced levels of supervision and observation has traditionally been used as a planned strategy to manage risk of potential violence.

Despite noting the widespread use of special observations within inpatient settings, however, these authors also highlight the paucity of research into this practice. Bowers et al (2000) noted a complete lack of empirical research into their use, with Jones et al (2000) noting that the little research available comes from small qualitative studies that have primarily focused on the management of the suicidal patient and largely involved the interviewing of patients some time after the event; often post discharge. This lack of research appears to be slowly changing, however, with Whittington et al (2006) highlighting that 'a research base for enhanced observation exists but is only in its infancy' (p167). They also noted the 'limited research base on the use of enhanced observations to manage the potential for violence' (p168),

As with the review of the literature on the patient and staff experiences of seclusion, an electronic database search of AMED, BNI, CINAHL, PsychINFO, Cochrane Library, ebrary, Intute, MEDLINE, ProQuest, Scopus, Web of Knowledge and Wiley Interscience, was used for the terms observatio* and nurs* with violen* or aggress*. This search found a distinct lack of existing research, with just one existing study noted. The authors of this one study, (Mackay et al, 2005), were also

unable to find any previous literature on its use for this purpose; professing this to be a neglected area of study given that the expectations for both the nurse and patient may be very different from those when used for the management of suicidal patients. This lack of previous research on the use of special observations for the management of violence and aggression also extends to the use of special observations for any given reason within a secure environment; a point noted by Whitehead & Mason (2006) in their study within a medium and low secure unit who commented on a complete absence of previously published literature on the use of special observations in forensic settings.

This lack of study of special observations within secure environments is considered a significant gap in the literature given the potential intrusive and distressing nature of this intervention (Neilson & Brennan, 2001). Similarly, Barker & Cutliffe (1999) called for the practice of special observations to be reviewed claiming it had primarily become a custodial rather than therapeutic intervention; a point noted in the literature on the historical cultures of the high secure hospitals. Barker & Cutliffe (1999) further noted that despite the rhetoric of being supportive, the supervising role is often seen as custodial. Bowles et al (2002) also highlighted the over use of formal observations as a custodial and defensive practice that can contribute to a sense of dehumanisation and isolation. Further still, Dodds & Bowles (2001, p187) also found that whilst undertaking enhanced observations nurses' activities were characterised as 'control orientated interventions' which contrasted with 'care orientated interventions'. The literature suggests that principles of support and engagement through increased levels of observations can be often over shadowed by controlling and custodial staff behaviours.

It is also noted that the existing studies on special observations have been largely descriptive in nature and have found a similar absence of evidence regarding efficacy to that of seclusion (Bowers & Park, 2001, Manna, 2010)). In their systematic review of containment strategies with patients with mental illness, strategies that included the use of special observations, Muralidharan & Fenton (2006) concluded that "current non-pharmacological approaches to containment of disturbed or violent behaviour are not supported by evidence from controlled studies" (p.1). It can be seen, therefore, that despite increasing use within a variety of psychiatric settings, there remains limited evidence supporting efficacy or

exploring staff of patient views; particularly in forensic settings and where used in the management of violence and aggression.

1.13 Overlap and differences in seclusion and special observations

Whilst the definitions of seclusion and special observations clearly differentiate between the two interventions, at the research site there are often overlaps in practice and different monitoring and auditing arrangements. This overlap can arise when patients in seclusion are allowed periods outside of the locked room for assessment of mental state and behavioural presentation; a common approach to the management of seclusion at the research site as highlighted in the recent independent review of seclusion across the three high secure hospitals commissioned by the Department of Health (DoH, 2010).

At such times patients are routinely supervised by a prescribed number of nursing staff and whilst, from an organisational perspective, they remain subject to the procedures outlined in the hospital seclusion policy (Mersey Care NHS Trust, 2008) there is little observable distinction between the supervision afforded the patient during these times and that afforded patients purely subject to special observations.

In practice, therefore, patients who have experienced periods of seclusion at the research site will have also experienced periods outside the seclusion room whilst supervised and supported by nursing staff; in essence being subject to special observations whilst remaining subject to the restrictions and requirements of a seclusion regime and the policy guidance that governs its use. The importance of this potential overlap and potential impact upon staff and patient views is discussed further in the methodology chapter.

Whilst the views of both staff and patients are considered an important focus of this study, of further particular interest are the differences in how both the organisation and external stakeholders consider the importance of each intervention. Whilst the use of seclusion courts a great deal of both internal and external scrutiny and gaze, the use of special observations fails to attract similar attention.

Requirement	Seclusion	Special Observations
Internal monitoring of practice	Yes - multi-disciplinary group tasked with monitoring, advising and reporting on practice	No
Internal monitoring of prevalence	Yes – monitored within internal governance structures	No
Internal monitoring of costs	No	Yes – financial costs monitored
External reporting on prevalence	Yes – Reported to Strategic Health Authority as part of Key Performance Indicators	No
External comparison of practice	Yes – Key Performance Indicators compared between all high secure hospitals by Department of Health	No
External monitoring of practice	Yes – Monitoring of practice across all high secure hospitals by Department of Health, and external monitoring by Care Quality Commission.	No

Table 3: Monitoring, governance and reporting differences between Seclusion and Special Observations at the research site

Table 3 (above) demonstrates the differences in both internal and external monitoring and governance arrangements, policies and practice guidance, and differing statutory and external reporting requirements. This demonstrates how seclusion is far more regulated, monitored, audited and reported on than special observations; with the only concern about the use of increased observations appearing to be financially driven.

A final issue of relevance to this study is the potential differences in views, perceptions and opinions of both staff and patient groups to each intervention. Whilst both may impact upon the individual staff or patient in different ways, of particular interest is the degree of acceptability or stigma each group attach to each, the psycho-social impact upon the individual, and the role of each intervention in the maintenance of organisational culture and shows of power, control and strength. These issues are explored and discussed in the findings and conclusion chapters.

CHAPTER 2 - METHODOLOGY

Methodology

2.1 Chapter structure

This chapter describes the methodological process undertaken. It will identify aims and research design, and continue with discussion of researcher positionality, identity, and the process of reflexive inquiry. Finally it describes the phases of the study, data collection, analysis and rigour.

2.2 Aim

The aim of the study is to explore the use of both seclusion and special observations in a U.K. high secure forensic psychiatric setting as a planned intervention in the management of violence and aggression. It investigates the beliefs, perceptions and experiences of both staff and patients to these interventions, moving beyond the descriptive to investigate and interpret the meaning, feelings and views attributed to these approaches by the participants from their frame of reference.

2.3 Research design

This part of the chapter will discuss research design; specifically grounded theory as the chosen methodological approach. It will consider its development and use in social research and illustrate its suitability as a method for the study of seclusion and special observations in this specialised health care setting.

Developed in the mid 1960's by Barney Glaser and Anselm Strauss (Glaser & Strauss, 1967) grounded theory offers a structured and systematic approach to qualitative social research. It allows for the identification and exploration of the conditions that give rise to specific social processes or events (Polit, Beck & Hungler, 2001), with the resulting examination supporting the development of theories as they emerging from the collected, analysed and interpreted data (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

It has been argued that this early work by Glaser and Strauss was positivistic in orientation (Bryant 2003), and whilst maintaining the principles of systematic and rigorous enquiry, it ultimately provided qualitative researchers with

a framework and systematic structure from which to move from description through to analysis and interpretation; to develop theories that were contextually based and grounded in the participants' view of their world (Charmaz, 2006). It allowed researchers to explore not only participant's experiences but to interpret and conceptualise these; to develop theory from the discovery of concepts and categories and examination of their relationships (Charmaz, 2006).

Grounded Theory brought the pragmatism of symbolic interactionism to scientific enquiry (Goulding, 2002), and with it the assumption that reality is constructed from a person's experiences and interactions and of the meanings they attribute to these. Symbolic interactionism assumes that people react to events based upon prior experiences and interactions and that people consider their actions by interpreting and eliciting meaning in situations rather than responding mechanistically (Goulding, 2002). It could be argued, therefore, that Grounded Theory can be viewed as a systematic approach to not only describing the complexities of the social and cultural processes that influences behaviour, but also a framework by which to elicit the meanings behind these reactions to events and interpret the individual's perspectives on reality and how they make sense of their world. The explanatory power of Grounded Theory can "illuminate common issues for people in a way that allows them to identify with theory and use it in their own lives (Mills et al, 2006)

It is 40 years since the introduction of Grounded Theory and whilst its guidelines and systematic framework remain an integral part of its process, its growth in popularity with healthcare researchers has come with a divergent shift in thought. This shift further developing the process based upon a more social constructivist approach; adapting the process to use "basic grounded theory guidelines with 21st century methodological assumptions and approaches" (Charmaz, 2006, p9).

This divergence in thought largely focuses upon the relationship between data and theory, the issue of theoretical assumptions, and the verification of theory (Kelle, 2005). Glaser continues to argue that theory should emerge from the data and that pre-conceived knowledge or assumptions should not be brought to the process. (Glaser, 1992) This 'Glaserian' approach advocates an inductive

approach where the emergence of concepts should be facilitated without prior reading of literature and without the contamination of data. He argues that data should not be forced into categories derived from pre-conceived theoretical codes and that if the researcher can put aside preconceived ideas and knowledge then theory will emerge.

In comparison, Strauss developed his approach initially on his own, but latterly in collaboration with Juliet Corbin (Strauss, 1987; Strauss & Corbin, 1990; 1998); acknowledging the prior experience and knowledge of the researcher and pre-existing literature and theories to be relevant to the research process. They argue that this provides 'theoretical sensitivity' which can enhance the identification of theoretical categorisation and allow for greater understanding and conceptualisation of the phenomenon being studied.

Further differences between the two approaches can be seen in the principles underpinning the coding process. Whilst Glaser advocates a more loose and flexible adherence to coding; allowing the theory to emerge unrestricted and without influence, Strauss & Corbin are "tightly prescriptive" (Stern, 1994, p220) in that they believe the coding system should be rigorously and systematically applied. Referred to as the 'coding paradigm', this is the process by which Strauss & Corbin (1998) believe the relatedness of categories and subcategories are grounded in the conditions in which the phenomenon occurs, the actions or interactions resulting from the phenomenon, and the subsequent consequences or outcomes arising from any actions or interactions.

A final significant difference between 'Glaserian' and 'Straussian' approaches can be seen in the way both consider the process of theory generation. Glaser holds that if theory is allowed to develop from the data without bias or influence then multiple theories may emerge and that each will represent a reality from the perspectives of those studied. Strauss & Corbin, however, place emphasis upon not only theory generation but also theory verification. With this they contest that theoretical explanations should be replicable given a similar set of conditions studied from the same theoretical perspective and if the same rules for data collection and analysis are followed (Denzin & Lincoln, 1994).

Further development to grounded theory as a method has been brought about by Charmaz (2000; 2006) to include a more social constructionist approach. Charmaz (2006) argues that there are multiple realities and that any generalisations made from theory can only be considered as partial and conditional in that they are situated in time and social context (Charmaz, 2009). Rather than considering grounded theory as a rigid process in which each step has to be rigorously applied, Charmaz holds the methods of grounded theory to be a collection of guiding principles and practices rather than a set of unyielding and inflexible prescriptive steps. She emphasises that rather than being discovered, theories are constructed through the researcher's involvement and interactions with people, perspectives and research practice; that theories represent an interpretation of the studied world, not an exact representation of it (Charmaz, 2006).

An influencing factor in adopting a grounded theory approach for this study was its value in the study of poorly understood and under-researched areas of clinical practice. McCann & Clark (2003) noted that where there is little known about the topic in question, and where there is interaction between patients and nurses, a grounded theory approach is particularly fitting. Goulding (2002, p55) also noted the value of Grounded Theory when the "topic of interest has been relatively ignored in the literature or has been given only superficial attention. Staff and patient experiences of seclusion and special observations within a high secure forensic environment are areas of practice that are poorly understood and scarcely researched.

Further influencing factors were the suitability of Grounded Theory to exploratory studies of human interaction and small scale research (Denscombe, 2010) and in studies where the researcher "wishes to investigate practical activity from the participant's point of view" (Goulding, 2002, p110).

A further influencing factor in this choice of methodological approach was the nature of interventions to be studied. Seclusion and special observations as events are influenced by processes, interactions and interpersonal encounters that occur within distinct social, cultural and temporal contexts. To explore and examine these from the perspectives of the staff and patients who experience them requires

one to move beyond a descriptive level; not only to view these events from the perspective of the respondents, but to attempt to understand the significance and meaning as attributed by them. A grounded theory approach offered this opportunity to move away from the descriptive and to progress to an interpretive theoretical explanation of their world; offering occasion to validate existing theories and develop new theories that may help identify strengths and weaknesses to existing practice (Field & Morse, 1990).

The social constructivist approach to grounded theory advocated by Charmaz (2000; 2006) appeared to the researcher to be particularly suited to this study. Perhaps first and foremost its relativist ontological position more readily fits with the researcher's own perspective than a positivistic view; a relativist outlook which holds that "the world consists of multiple individual realities influenced by context" (Mills, Bonner & Francis, 2006, p2) rather than the existence of a single objective reality.

One final, but particularly important factor influencing the choice of a grounded theory from a Charmaz perspective was the researcher's own specific experience and position with respect to the participants and the research site; an issue discussed in detail below.

2.4 Knowledge, experience and positionality

Many methodological approaches to qualitative social research, such as ethnomethodology, phenomenology and even the classic 'Glaserian' approach to grounded theory advocate the placing to one side of prior experience, knowledge, values and preconceptions (Glaser, 1992). This tenet of impartiality and clear objectivity places importance upon the researcher to remain as either passive observer or interacting from a detached and independent perspective. According to the 'Glaserian' methodology this will allow for the emergence of theory without bias or prejudice, and whilst this concept of objectivity is also noted by Strauss & Corbin in their adaptation of grounded theory, they also recognise advantages to the researcher bringing prior knowledge to the process in so much as to assist in the identification of theoretical categorisation. They argue that the researcher should use this prior experience and knowledge to inform rather than influence; to help separate the relevant from the irrelevant (Strauss & Corbin, 1998).

Charmaz, however, considers the role of the researcher as being more of an integral and interactive part of the research process. Rather than passive observer she holds the researcher to be "part of the world we study and the data we collect" (Charmaz, 2006, p10). This is not to say that preconceptions or biases should enter the process; indeed Charmaz also maintains the importance of setting aside prior values and maintaining objectivity. What is noted as important, however, is the researcher's questioning of their own interpretation of the data and potential influence through the process in order to reflect and detect any potential bias or contamination. From an epistemological perspective, this constructivist paradigm recognises the inter-relationship between the researcher and the researched and notes the importance of the researcher recognising the impact of their 'humanness' on the outcome (Mills et al, 2006).

This process of reflexivity is particularly important in qualitative interpretive research, with an awareness of how one's own assumptions and experiences can impact upon the research process considered necessary if the researcher is to recognise the potential influences that they may bring to the analytic and interpretive processes. Further, with the open disclosure and discussion of these influences the reader will be better positioned to evaluate the relevance and importance of researcher experience and position, and their effects upon the research process. The importance of reflexive inquiry in this study is discussed in depth later in the chapter, where its relevance is highlighted, not only given the researchers prior knowledge and experience, but particularly given the professional position held at the research site.

The researcher brings to this study over 29 years experience as a forensic psychiatric nurse at the research site. These experiences have been gained through a number of clinical and managerial roles ranging from unqualified health care assistant up to and including senior manager. This has understandably provided the opportunity for the nurturing and development of ideals, values and opinion, for the gathering of knowledge and understanding about the high secure system of psychiatric health care and its use of approaches to manage violence and aggression. Of particular note and relevance is how this experience and knowledge has being gained and developed whilst a member of the cultural group

that has been so often publicly criticised and judged. The researchers professional ideals and perspectives have undoubtedly been influenced by exposure to, and membership of the cultural world of the UK Special hospital system.

The researcher's employment commenced at a time of the structured, regimented and controlling regimes that were subsequently described as dehumanising (Blom-Cooper, 1992). Subsequent experiences were gained over a period which has been characterised by changing values, morals and practices concerning detained patients in general, and within forensic psychiatric care at a time where policies, procedures and practice were viewed from the outside as abusive, punitive and over-controlling. During this time, however, there has also been experience of the changing philosophical values and ideals influencing high secure care as a result of integration into the mainstream NHS and exposure to the political pressure and direction arising from inquires and inspection.

The researcher's exposure to the changing culture of the high secure system, together with experience of the practices of seclusion and special observations from both historical and contemporary perspectives, provides an opportunity for reflexive inquiry. It is this reflexive approach that provides a lens for the reader to view the influences and impact of this knowledge and experience upon the research process.

2.5 Reflexive inquiry

This part of the chapter focuses upon the issue of reflexive inquiry. The section starts with an introduction to the concept itself and continues by noting and exploring its fundamental importance to this piece of research given the nature of the study and the positionality of the researcher.

The section continues by discussing the relevance of reflexivity for understanding potential power relations present within high secure forensic care and their impact upon the research process. It highlights the importance of reflexivity in informing, and subsequently shaping all aspects and stages of the study; especially data collection and interpretation. Finally it emphasises the need to move from a theoretical construct through to reflexive action and the particular challenges and opportunities associated with this.

It is important to stress this point that reflexivity is not simply a concept that can be talked about in one short part of a chapter. A researcher is not able to talk of using a reflective approach without demonstrating its bearing upon the process of inquiry and of its impact upon self and his relationship with the participants in the study. It is an active process, not a passive point of discussion.

It is with this in mind that the following sections are presented. They provide the lens through which the reader can start to understand and appreciate the place of the researcher within the study. They are provided as a means of emphasising the need to expose and lay bare those aspects of researcher influences and experiences and the ways in which they may have impacted upon the research journey. For the reader it emphasises the process of researcher self-reflection, helping them understand the researcher's positionality and process of reflexive thought. It will allow the reader opportunity to consider the decisions, assumptions, and interpretations made by the researcher, and theories generated from the data, against the backdrop of researcher influence and experience. As noted by Koch (1998), it is in the signposting of the decisions taken by the researcher that allows the reader to ultimately judge the quality of the research for themselves.

2.5.1 Concept of reflexivity

Whilst reflexivity is commonly used within modern qualitative research, it continues to lack a standardised definition, with scholars often attributing different meanings, connotations and nuances depending upon their specific ontological and epistemological standpoints and personal experiences of its use within research practice. The centrality of a reflexive analytical perspective in qualitative research has been long established (Bolam et al, 2003), however, with its value in promoting transparency and honesty noted (Northway, 2000).

As a basic concept it has been held to be "a turning back on oneself, a process of self-reference" (Davies, 2008; p4). a process that allows for the scrutiny of the researcher's experiences, decisions and interpretations so that the reader can assess the impact and influence of their interests, positions and assumptions on the inquiry (Charmaz, 2006). It is a conscious attempt at identifying the social understandings produced through inquiry, and the way in which outcomes have

been affected and influenced by the researcher and the process of research itself (Hardy et al, 2001).

Often used interchangeably with the term 'reflective', it is important to note some distinct differences that take the process of reflexivity beyond mere reflection. To 'reflect' suggests a degree of (often) passive introspection and self-analysis without the requirement to self-criticise, act, or respond to consequences of action. Reflexivity, however, requires not only the introspection evident in 'reflection', but is also an active process that informs how the researcher undertakes inquiry and relates to the study and its participants (Charmaz, 2006) and makes this reciprocal relationship explicit (Lamb & Huttlinger, 1989). Reflexivity is the process that allows for recognition of the researcher's impact upon the process of inquiry and how assumptions, values, biases and prejudices brought to the process are explicitly and critically examined (Northway, 2000) to produce new ways of understanding the research.

Reflexivity is about how we engage in critical appraisal of our own research (Davies, 2008) at all stages of the process; from choice of topic, participant selection, methodological approach, data collection, and ultimately analysis and interpretation. This includes how issues are perceived in particular ways, and insight into the processes and influences that lead us to make particular assumptions and analyses in preference to others.

Reflexive approaches to qualitative inquiry has increased with the rise in popularity of social constructionism, and the recognition that situations and events can be described and interpreted in different ways. This focus upon epistemological issues of how we come to know about the world, rather than the ontological essence of knowledge, encourages us to challenge what we perceive to be the routine, mundane and taken for granted, and allows us to consider how the world is socially and culturally sensitive and ordered (Taylor & White, 2008); to emphasise the socially situated nature of knowledge (Davies, 2008).

From a reflexive perspective this social constructionist approach encourages us to interrogate our accounts of the world and to explore the diversity of experiences (Riley et al, 2003) and to recognise that the orientations and values we bring to our inquiries are themselves shaped by a range of social, cultural and historical factors (Hammersley & Atkinson, 1995). It ensures that any biases or

prejudices are explicitly acknowledged, explored and made public as much as possible (Waterman, 1998). If we are to accept this socially constructed view of knowledge then a reflexive approach has to apply to all aspects of our inquiry; to not only reflect upon what and how we have studied, but also to address and interrogate the assumptions made and theories generated (Taylor & White, 2008).

Whilst this 'epistemic' element of reflexivity calls for the challenging of assumptions and the questioning of what we know and how we claim to know it (Johnson & Duberley, 2000), other elements of reflexivity require us to remain cognizant of the methodological aspects of reflexive inquiry; what was studied and how it was conducted (methodological reflexivity), and of the exploration of the rationales and motivations behind the choice of inquiry, together with any potential disciplinary limitations and ideological values (disciplinary reflexivity). The importance of these specific elements, or types of reflexivity will become evident when discussing the relevance of reflexivity given the nature of the study and the specific positionality of the researcher in this study.

2.5.2 Relevance and researcher positionality

It is appropriate at this stage to discuss the relevance and importance of adopting a reflexive approach in the undertaking of this particular study. Consolidating on the theoretical perspectives noted above, and relating them to the issues faced in the study, it brings to the fore the potentially very significant issues associated with the researcher's managerial position at the research site, relationships to the participants, and cultural, historical and social influences and experiences. It begins to expose the frame of reference from which the researcher approached the study.

The permeation of reflexive thought throughout social inquiry requires reflection of choices and decisions at each stage of the process. Even before we start to collect the data and begin the analytical and interpretive work, we need to 'turn back on ourselves" to allow for introspection to explore motivations, desires, inspirations and influences in such areas as choice of topic, selection of participants, epistemological and ontological positions and methodological approach. It is through this that the researcher's self-identity is exposed and a transparent exploration and examination of their situated knowledge undertaken. It

is these interpersonal, political and institutional contexts in which the researcher is culturally, historically and socially located that play a key role in shaping these decisions (Mauthner & Doucet, 2003).

Exploration of these issues requires the researcher to acknowledge, consider, and at times self-criticise their positionality; to de-construct and subsequently re-construct a sense of identity. With respect to this particular study this has required the researcher to consider his cultural, social, and political identity, and to note and accept the dynamic and shifting nature of relationships at different stages of the process; even at different stages of individual interviews. This multiplicity of positions includes recognition and examination of the competing and contradictory identities that may have been presented and perceived, and which included researcher, practitioner, manager, friend, colleague, care giver, facilitator/enabler, controller, and gaoler.

It is through the open examination of these competing, and at times contradictory roles and identities that the challenges associated with insider-outsider research can be explored, and from which the reader will be exposed to the particular challenges faced through the researcher's specific positionality in the undertaking of this study.

2.5.3 The 'insider' v 'outsider' debate

It has been noted how "all researchers are to some degree connected to, or part of, the object of their research" (Davies, 2008; p3), and that when researching within one's own organisation the researcher's "relationship with the research subjects must be acknowledged and explored as part of a wider social and political engagement that goes beyond the traditional researcher/participant relationship" (Freshwater & Rolfe, 2001; p534).

It is from such views that the notions of 'insider' and 'outsider' researcher positions can be situated, and subsequently unpicked and examined. These concepts are based on the rationale that some researchers are in some way 'closer' to the participants than others; that they share some common shared social or cultural identity. Such 'insider' positions are characterised by shared social identities with the participants (Chavez, 2006) and by the proximal distance

between the social, intellectual and social positions of the researcher and participants (Banks, 1998).

Researcher's undertaking social inquiry in their own organisation are often considered to be 'insiders'; to have some special knowledge or understanding that would otherwise be unavailable or non-observable to an 'outsider'. Indeed it has been argued by some that 'insiders' are uniquely positioned to enable closeness and familiarity, and to appreciate nuances and insights that would otherwise remain hidden (Chavez, 2008). Kanuha (2000) highlights how 'insiders' often come to have a greater realisation and understanding of the participant's cognitive, emotional and psychological precepts, and of cultures and practices in the field.

It has been argued that 'insiders' are more likely to be aware of the cultural and social taboos, implicit meanings, jargon, and shared understandings within an organisation (Coghlan & Casey, 2001); insight into the informal, the implicit and the unstated. Even further, Brannick & Coghlan (2007) suggest that 'insiders' are able to obtain richer data as a result of using the internal jargon and use of their own internal experiences and knowledge.

In highlighting these potential advantages of 'insider' positionality, however, one must remain cognizant of some very real issues that can impact upon any preferential advantages to such a position. Perhaps first and foremost one must appreciate the dynamic nature of the relationship often present between researcher and participant. Naples (1996) emphasises the fluid nature of these interactions, noting how relationships can prove ever shifting and experienced differently at times by both researcher and participants alike; even within the same interview on occasion. Reflexivity requires the researcher to explore how they present to participants, and consider how participants respond to, and ultimately perceive them. The shift from 'insider' to 'outsider' at any stage of the process may impact upon the richness and quality of the data produced, with any 'insider' advantage strengthened or weakened depending upon these shifting shared cultural and social identities and experiences between researcher and participants (Labaree, 2002). There is the potential for participant responses to be affected and contaminated by their perceptions of the researcher's identity (Kanuha, 2000). This issue of researcher identity is discussed in detail later in the chapter.

Further potential disadvantages to 'insider' positionality have been noted, however, with some claiming that the relationship and shared social identity between researcher and participant can prove too close (Brannick & Coghlan, 2007). Some have even argued against researchers undertaking social inquiry within organisations in which they have a work role, suggesting that the dual role of employee and investigator are incompatible (Morse, 1998). Others still that such role complexity can lead to conflicts of loyalty and identification dilemmas (Coghlan & Brannick, 2001) and potential bias, blindness, lack of probing and false assumptions (Coghlan & Casey, 2001; Gergen & Gergen, 2003).

Whilst awareness of the potential benefits and caveats of having 'insider' situated knowledge can provide valuable reflexive insights into the effects upon researcher, participants, and the process of inquiry in general, it has been argued that having a theoretical knowledge about such effects does not in or of itself necessarily provide guidance or instruction on how to use such information (Kanuha, 2000). The process of reflexive critique is one in which there is often a lack of clearly defined starting or ending points. Whilst a reflexive approach requires and demands rigorous inspection of one's own influence upon the research process, there may be limits to the extent of our awareness of such influence (Mauthner & Doucet, 2003) and the potential to move the focus of the inquiry from the object of the study to the researcher himself (Finlay, 2002). It should be noted that narcissism and self-indulgence can prove destructive if remained unchecked (Marcus,1998; Davies, 2008), with too much introspection increasing the potential for in-action (Waterman, 1998).

2.5.4 Managing 'manager' research

In opening up for inspection the specific positionality of the researcher in this particular study with the multiplicity of roles encountered, and the challenges and self-critique undertaken, the issue of the researcher's professional role as senior manager within the organisation of study has to be explored and acknowledged. It is only though the recognition of the factors associated with this role complexity that the reader will truly begin to appreciate the frame of reference from which the study was approached and the potential impact of this role upon the process of inquiry.

Whilst Brannick & Coghlan (2007) note that Managers may have specific knowledge of their organisation and have an appreciation of what is acceptable to talk about, what is taboo, and what critical events occur and hold meaning to the organisation and its community, there are clearly specific challenges for managers above and beyond those ordinarily encountered by 'insider' researchers. Such areas include elements of role conflict and duality, exposure of underlying assumptions, participant response and reaction to the researcher, and the power imbalances between researcher and participants that can be magnified above and beyond those ordinarily found in social inquiry encounters. This is a situation even further exacerbated given the location of the study and the potentially disenfranchised position of the patient participants.

Whilst the specific issues of power relations between researcher and participants in this study will be explored in detail as the thesis progresses, it is important at this stage to recognise and highlight the importance of reflexivity in understanding and exploring the significance of power imbalance, not only between staff and patients in a high secure forensic clinical environment, but also within many social inquiry encounters.

It has been highlighted we should be particularly sensitive to power relations within health care research given that patients are often used to being interviewed by professionals who are often perceived as being in a position of power (Davies, 2008), and where there is often little thought given to matching cultural or social identities between health care professional and patient. It would be sensible to presume that equality does not exist between interviewer and interviewee (Mason, 2002).

Neill (2006) has suggested that whilst researcher-participant matching for such socio-cultural factors as age, gender, ethnicity and social position may overcome some of the potential power imbalances inherent within health care research, it is often more important to reflexively recognise and acknowledge that honesty regarding socio-cultural and historic differences between both can prove more beneficial than attempting to assume some 'insider' characteristics. This argument has been supported by Mallory (2001) who proposed that trust and disclosure can be improved through the explicit sharing and exploration of personal and professional values between researcher and participant.

By adopting a reflexive process of introspection and self-analysis such power dynamics can often become more visible (Finlay, 2002; Riley et al, 2003), especially within interview situations (Daley, 2010). It is in the recognition of the socio-cultural dynamics of the interview process, and awareness of the power relations at play, that reflexive analysis can help in ensuring shared meanings and socio-cultural dynamics are not taken for granted (Davies, 2008), and beyond this are used to enhance interpretation. It ensures that assumptions about the nature of participant knowledge are not made, and acknowledges that how participant's articulate their perceptions and perspectives may not always accurately reflect their own social realities (Davies, 2008). Reflexive thought requires us to remain aware that in situations where there may be a significant power imbalance, participant responses may not be an accurate articulation of their perceptions of their social world, but could be reflective of other issues and factors. These may include responses resulting from the desire to gain favour or please, a tendency to acquiesce, perceived pressure to confirm, from playing perceived expected roles, or even from fear or personal concern.

These issues were of particular concern in this study as a result of the researcher's current and previous roles within the organisation. These roles had the potential to be perceived by participants as care-giver, friend, colleague, advocate, gaoler, manager, and even potential agent of the establishment, It is by the author exposing and exploring these perceived roles throughout the thesis that the reader will gain a better appreciation of researcher influence upon the individual participants and process as a whole. To aid this, elements of researcher biography will be presented throughout the study to open up for inspection the thoughts, assumptions, dilemmas, challenges, confusions, contradictions, and interpretations made and experienced.

2.5.5 Researcher identities

As noted earlier, reflexive inquiry requires the researcher to examine the potential effects and influence he brings to the research and the effects upon those participating in the study. Research interviews are social interactions as and of themselves (Drew et al, 2006), are both contextual and negotiated (Charmaz,

2006), and are situations in which both parties have different roles to play in the research process (Legard et al, 2003).

Whilst both researcher and participant may indeed have different roles to play, Denscombe (2010) notes that it is fairly well accepted that participants' respond differently depending upon characteristics of the interviewer; characteristics such as social status, educational background or professional expertise. Indeed Charmaz (2006) notes that interviewers must remain mindful of how they are perceived and how past and present identities can influence the research process. Davies (2008) argues that this requires the researcher to maintain an awareness and appreciation of the social relationships between interviewer and participant, and not to presume shared context. Differences in both power and status may be acted upon during the interview (Charmaz, 2006) and the researcher needs to remain aware of these and the potential for differences in cultural meanings between interviewer and participant (Davies, 2008).

This issue of roles and identities reinforces the notion that the interviewer is himself and instrument of the research process (Kvale, 1996); a fundamental tenet in reflexive inquiry. For the researcher to become aware of such identities and influences however, he cannot rely solely on interview recordings. It is here that the use of memos and field notes taken at the time of, or shortly after the interview prove invaluable (Davies, 2008) and can allow the researcher to fill in some of the gaps in the information that transcripts or tape recordings can miss (Denscombe, 2010)

As part of the process in this study, the researcher made memos both during and after each interview so that together with analysis of the interview transcripts there could be reflection upon the interpersonal dynamics played out between both parties. This analysis allowed for identification of not only the participants' perceptions of researcher identity, but also allowed the researcher to identify the different roles he himself adopted towards different participants. As highlighted earlier, these roles included researcher, practitioner/care giver, manager, friend, colleague, facilitator/enabler, and controller/gaoler.

This diversity of roles should not be surprising given the different relationships the researcher had with each participant, some relationships that had developed and indeed changed over a number of years. With respect to the patient

participants the researcher had provided direct care to 6 of the 12 over a number of years during his time in ward based roles, although none since 2004. The other 6 patients were known to the researcher by name only or through brief passing social interaction; not in a direct or even indirect care giving role. Of the staff participants the researcher had worked directly with 5 during his time in ward based roles, being line manager in different roles to all 5 at different times. Whilst the other 7 were known to the researcher as a result of having senior managerial responsibility for them, contact had only ever been to exchange pleasantries in passing. The following sections highlight some of the different roles identified through analysis of the interview transcripts and review of memos. They are presented here to illustrate the diversity and transiency of identities perceived and to open up for inspection the interpersonal dynamics encountered between researcher and participants.

It is noted that in many of the interviews the rate of information flow changed as the interview progressed, with a marked move from slow and guarded to more open and expressive. In reviewing the memo's it was evident that the researcher had indicated he felt the participants relaxing as time progressed. Examples of this included comments such as "appears guarded", "doesn't want to go there", looks intimidated", "looks scared", "pulling teeth !!" during the initial stages of some of the interviews, though to "definitely relaxing", "opening up++", won't stop talking ☺", "very personal disclosure", "really wants to get this point across", "really flowing" and "good use of reflection" as the interviews progressed.

Whether this change in flow was wholly due to a change in researcher identity or whether the participants were simply becoming more accustomed and at ease with the interview process is unclear. What did appear evident, however, was that no single researcher identity remained static throughout the interviews and that these roles appeared to change as the interview progressed. There was no evidence from either the transcripts or the memo's that suggested to the researcher that one particular identity dominated. Indeed a change in researcher identities within interviews was expected and perhaps inevitable given the socio-cultural context in which the research was undertaken and the positionality of the researcher himself. This invariably meant that at times the participant demonstrated evidence of perceiving the researcher in a number of roles, with these often appearing to shift depending upon the subject area being discussed,

the emotional intensity of the interaction, and at times the need for self protection or validation of their statements.

2.5.5.1 Researcher

This particular identity was apparent throughout the interviews, with both patient and staff participants appearing eager to impart information to the researcher in expressing views, opinion and experiences. As highlighted earlier, however, it often took some time for the participant to relax and open up in the interview. Whilst this may in part have been a result of the participant feeling more at ease as the interview progressed, a review of the transcripts and memo's also suggests that on many occasions this reflected a shift in perceived identity to one of researcher.

This was evidenced by several of the participants, both staff and patients, initially disclosing information that appeared self-serving and following their own agenda. For example some staff were clearly trying to impress the researcher, whilst some patient participants utilised the opportunity to complain, or have the researcher influence or address personal issues or concerns. Others still simply appeared to want to have their voice heard. What was evident in the review of the data and memo's, however, was how each participant clearly provided a narrative that imparted to the researcher knowledge and understanding of their own beliefs, perceptions and experiences of the subject matter relevant to the study.

2.5.5.2 Practitioner/Care Giver

Several of the patient and staff participants' made reference to the researcher's clinical practice and professional skills. From a staff participant perspective this often appeared to be an attempt at eliciting from the researcher recognition or validation of shared practice values or behaviours. For example several staff participants commented on the previous experience of the researcher in using seclusion and special observations from his time in ward based roles, or acknowledged his experience in leading in the hospital's drive to reduce reliance in the use of seclusion. Examples included

"haha, you mean you cant remember?. Has it been that long since you were secluding people" (SR3)

"I think seclusion has come a long way since you were on the wards to be honest" (SR4)

"I guess once a nurse always a nurse, you know Des, You never lose that wanting to help people or that sense of achievement when someone difficult starts getting better" (SR7)

There was also recognition of the researcher as a care giver from several patient participants, with these participants appearing to assume the researcher had detailed knowledge and understanding of what was being told him without an apparent need to offer detailed explanation. This was particularly evident when the participant would be describing aspects of care or treatment, or when recounting incidents of seclusion or special observations. On further occasions there was recognition from several patient participants of previous encounters with the researcher in which direct care was provided, and even at times the recounting of tales of when the researcher himself was involved in the seclusion of some of the participants. Examples of patient participants recognising the role of practitioner/care giver included

"as a nurse Des, you know these drugs fuck you up, physically like, they make you fat Des; slow you down, you know?" (PR12)

"you're a nurse Des, do you think that was right?" (PR2)

"all you nurses stick together; thick as fuckin thieves" (PR6)

2.5.5.3 Manager

Given the researcher's current position of senior manager at the research site it was perhaps inevitable that some of the participants recognised and responded to this. Several of the patient participants inquired about the researcher's title and job role; perhaps for clarification as this was only briefly identified in the patient participant information sheet. However, it was evident from the transcripts that several of the patient participants who were aware of the researcher's current managerial role within the hospital recognised this and made comments such as

"Des, you are the boss, you know what they're like sometimes" (PR12)

"All the influence you have over staff ..." (PR8)

This did not appear to be a barrier to communication or the imparting of information, however. As previously highlighted, the patient participants appeared to relax and open up as the interviews progressed and did not appear inhibited, influenced or intimidated by the managerial element to researcher identity. Some did try and use this position as a means of progressing their care, but this is discussed under the identity of facilitator/enabler.

In a similar vein to the patient participants, many of the staff participants appeared to start the interview tentatively and with short, closed answers. This was most evident in the participants with whom the researcher had no prior relationship. Whilst this may also have been a result of unfamiliarity with the research interview process, there were definite occasions where the review of memo's suggest concern on the part of several staff participants' about the reaction of the researcher to what was being said. Examples of memo entries include ""looks nervous", "appears to be looking for validation", trying to backtrack", "inconsistent !!!", "doesn't want to get drawn on this?", "keeping things close", "stock answer".

There was evidence from several staff participants of an awareness of the researcher's managerial role in statements such as

"You know, with all the monitoring you have us doing" (SR6)

"I think some staff are worried you will come down and bollock them" (SR11)

2.5.5.4 Friend

The perception of the researcher as friend was also identified through the transcripts and review of the memo's. Surprisingly, however, this was found in the interviews with patient rather than staff participants. Several patients made comments about their relationship with the researcher by making reference to past interactions and shared experiences. There was evidence of attempts at demonstrating camaraderie in the recounting of some tales of previous encounters, including seclusion events that both researcher and participant were involved in

either directly or indirectly, and recollection of past events and times during their hospital career they both shared. Examples of this included

"We have had some laughs haven't we?" (PR11)

"Remember when me you and Tony went to Liverpool, you and him always treated me well. You never treated me like a twat, Des. We've always got on haven't we?" (PR5)

"...it was you that got me out on that occasion after XXX put me in for nothing. I could always come to you if I had a problem with him. You always took my side" (PR12)

2.5.5.5. Colleague

It was evident from a review of the transcripts and memo's that several of the staff participants used statements and comments that inferred shared and mutual understanding. These would include recognition of past and current practices, explanations of their own behaviours and, at times, attempts at seeking assurances that these behaviours were acceptable to the researcher. This included multiple examples of staff participants stating

"you know what I mean?" (SR2, SR3, SR5, SR7, SR11, SR12)

"*you know what it's like?"* (SR2, SR3, SR5, SR11)

"you know the way it is?" (SR5, SR8, SR11, SR12)

There was also evidence in reviewing the researcher's memo's that some of the staff participants were attempting to draw on shared experiences and past allegiances to emphasise points and validate behaviour. Such examples included

*"it's not like when we were on **** Ward, you can't just lock patients up for nothing nowadays"* (SR3)

"remember when it was the case of 'who locked them up got them up'?" (SR5)

2.5.5.6 Facilitator/enabler

This identity was perhaps one of the most clearly identifiable and was evident in both patient and staff participant interviews. One particular staff

participant was a staff nurse at the time of the interview and was due to be interviewed for the position of charge nurse within a matter of weeks of the research interview being undertaken. As one of the staff whom the researcher had worked with during his time in ward based roles there was a prior relationship between both parties. Indeed the researcher had been supportive of the career development of this particular staff member during this time and encouraged him in his quest for continued promotion.

Throughout the interview it was clear that the participant had his own agenda to self-promote rather than always assisting openly in the research process. Questions were often met with answers mirroring the official philosophies and stated objectives of the hospital, and rhetoric offered in attempts at pleasing and influencing the researcher. This self-promotion included exaggerated descriptions of his relationships with patients, stated opinion of the high secure system, and of the therapeutic value of the interventions used to manage violence and aggression. Examples included the following response when asked if he thought high secure services did a good job

"I do indeed, yeah. I think they do a magnificent job personally" (SR1)

The following response was given when asked if he considered special observations to be therapeutic

"Absolutely, one of the most therapeutic interventions we do I think, in my opinion" (SR1)

And the following offered when asked about his relationship with his patients

"I have a fantastic relationship with patients" (SR1)

This particular participant also attempted to distance himself from negative staff behaviours in a way that recognised their presence but included a denial of participation. An example of this was noted when he explained that he always treated patients as individuals and discontinued seclusion at the earliest opportunity, although acknowledged that all staff did not do this,

SR1: *"that's how I do it, that's how I see patients individually"*

R: *"In your experience do other staff always do that?"*

SR1: *"No... its easy to keep people locked behind a door and give them nothing"*

Despite attempts by the researcher to steer the participant away from the superficiality of some of his responses and draw him into a more detailed discussion, this proved difficult to achieve at times, with the participant attempting to revert to shallow surface answers when provided the opportunity to do so. This was perhaps the most limited interview with respect to open discussion or free flowing narrative.

Similar attempts at influencing for personal benefit were evident in several of the patient interviews, where the participants attempted to take advantage of the current managerial role of the researcher. Examples of this included a plea by one patient to have the researcher exert influence in his responsibility as 'bed manager' for the hospital to facilitate a ward move.

*"I would like you to see if you could get me to **** Ward"* (PR3)

Another made requests of the researcher to assist in ongoing conflict with members of his care team

*"She doesn't come to see me and I've asked to have a change of RMO but they won't let me. Can you ask ****** to come and see me Des?"* (PR6)

A third asked the researcher to intervene in an ongoing conflict with one of the nurses on the ward.

"You've got to get him out of my face Des, he's a cunt, Des, you've got to move him" (PR5)

2.5.5.7 Controller and gaoler

Whilst to one degree or another all patient participants made references to the controlling nature of the approaches of both individual staff and the hospital in general, several made reference to prison cultures and attitudes of staff. They spoke of being treated like prisoners and of being punished as though they were in prison. When making these statements they would often broaden the perceived behaviours of one individual staff and attribute these characteristics and behaviours to groups of staff. On occasion these would include making reference

to the researcher's past roles on wards, where there would be inferences made as to the punitive or authoritarian elements of ward culture. Examples included

> *"You know what I'm like, if you kick me I'll kick you back. I don't mean really like but you know, saying wise. When we were on **** Ward I was treated badly so I reacted. It was hard on there, the rules were strict"* (PR7)

> *"I remember you secluding me on ***** Ward Des, remember? I spent 12 weeks in the box on that occasion. You remember? You wouldn't let me out til I took my medication, haha, and I wouldn't take it"* (PR3)

> *"Remember when we was on ***** Ward Des, you wouldn't let patients get away with shit like that. We would have been secluded for that"* (PR5)

This final example highlights not only a specific researcher identity, but also helps to demonstrate the changing nature of identities during interviews. This particular participant (PR5) had not only identified the researcher as contributing to and maintaining an authoritarian culture, and having controlling characteristics in a previous role, but had also identified him as 'friendly' and forwarded an example of a positive shared experience (see 2.5.5.4). On reflection, this is perhaps not surprising given the duality of roles that nurses often have to adopt in the provision of care within forensic environments.

2.5.5.8 Identities adopted by the researcher

As noted earlier, it was foreseeable that the participants would perceive the researcher as having a number of different identities. However, reflexive inquiry also helped the researcher to identify the different roles he himself appeared to adopt at different times within the interviews. Whilst one could see the tendency to focus upon the participants' accounts and narratives, it is through reflexive consideration that we can come to appreciate the active influences a researcher may have upon the interview process irrespective of characteristics or experience simply through direct action or inaction during the interview itself.

Examples of when researcher action or inaction may have affected identity were particularly evident when participants would make value laden statements. This was noted in many of the examples highlighted earlier when giving examples of different perceived researcher identities. Often the researcher would stay silent, perhaps naively, to encourage free flowing narrative, and would often fail to discount, challenge or attempt to re-focus the participant. It is on reflection and

through review of the transcripts that such silences and failure to interject at times may simply have perpetuated the specific researcher identity, with the participant assuming silence as validating their perception of the researcher and the role being played.

It was in this review of participant transcripts that the researcher was surprised at how easily, and often, he himself accepted the identity placed upon him by the participant and engaged with them in such a role. An example of this can be seen when a patient participant asked for help in getting him to another ward (see 2.5.5.6) and the researcher responded by saying

"I'll speak to Tony and your care team"

On reflection this response may not have been helpful to the research process as it had the potential to reinforce the identity that the participant had of the researcher and take the focus of the interview away from discussing topics and issues relevant to the study.

A further example from the patient participant transcript was noted when the patient participant accused all the nurses of sticking together and being thick as thieves (see 2.5.5.2). On this occasion the researcher stayed silent. On reflection this may well have reinforced this perception and placed the researcher firmly within that group of staff. Similarly when another patient participant recognised the researcher's status as a manager and stated that the researcher knew what staff were like (see 2.5.5.3) there was a failure on the part of the researcher to follow up this statement with inquiry. Again silence may have reinforced perceptions of staff and the identity of the researcher as a manager.

Reinforcing of roles and identities were also evident within the staff participant transcripts. A particular example of this was when a staff participant stated

"if I say something controversial will I get in to trouble" (SP10)

On reflection it was clear to the researcher that this particular participant was recognising his role as manager. On this occasion the researcher replied "No", which on reflection may, irrespective of providing reassurance, simply have validated the identity of the researcher for that participant. There was no follow up

inquiry as to why the participant felt such concern, or indeed any exploration of whether he had anything controversial to impart.

A further example occurred when one of the staff participants asked that a tale he wanted to recount regarding special observations be excluded from the official research process and told to the researcher 'off the record'. The researcher, rather than inquiring as to why the participant felt the need for this, or assuring him of the confidentiality of the research process simply acquiesced to his request. This action always sat uncomfortably with the researcher and was noted in the memo taken of the interview at the time, where it was noted 'should ask for the story to be included'. Unfortunately, however, this was never followed up by the researcher.

2.5.5.9 Impact of reflexive inquiry

The following section discusses the impact of using a reflexive approach to inquiry in this study, specifically in relation to its influence upon the study processes and relationships with the participants. It highlights the issues described earlier when discussing the elements of the 'insider v outsider' and 'managing manager research' debates, and illuminates further the challenges faced in light of the changing and differing participant and researcher roles played out during the interviews.

It was through the process of reflexive inquiry that the researcher was able to recognise the potential cultural, contextual and organisational biases inherent in the study of seclusion and special observations within an environment such as a high secure forensic service. The researcher was acutely aware of his 'insider' position at the research site. Extensive experience over a number of years had helped to nurture a personal and professional power base that had potential impact upon the many stages of the research process. The researcher held a position of authority within the organisation that was recognised by both patient and staff participants, and was particularly influential in the culture and practice surrounding the use of seclusion and special observations.

Further complications arose from the researcher's role as a senior manager, and with this the potential tendency to simply report on issues and practices that favoured the organisation and its staff at the expense of rigour and impartiality; to

fail to probe or question (Coghlan & Casey, 2001) or even to make false assumptions and judgements (Gergen & Gergen, 2003). This was a very real issue for the researcher and one he remained mindful of throughout the stages of the study. The internal conflict and anxiety generated through the need to examine and analyse based on the integrity of the data rather than organisational and professional safety was neither ignored nor underestimated. Reflexive inquiry requires and allows the researcher to recognise such conflict, to bring into the open the anxieties experienced, and to reconcile such conflict by adopting a neutrality and openness in the research writing that lays bare any preconceptions. It is this process that allows the reader the opportunity to assess, explore and examine the assumptions and interpretations made, and to judge for themselves any potential bias.

It was not only the nature of the research process that required a reflexive approach, however, but also an examination of the researcher's relationships with, and particularly towards, participants. This was of particular relevance given his 'insider' position at the research site, and experience grounded in ward based practice over a number of years. This experience and position provided potential for a common shared cultural and social identity with the participants. With staff participants this provided potential for perceptions of familiarity, camaraderie and joint experiences, and with patient participants a potential for stereotyping, bias, pre-judgement and reservation.

As a nurse of many years within a high secure environment there were elements of the staff participant narratives that resonated with the researcher; elements that proved familiar and ones the researcher could readily relate to. This gave rise to the potential to blindly agree, to fail to probe or question, or to take for granted what was being told. There was the potential to accept as comfortable and reassuring the shared experiences of the participants and the researcher. In contrast, there was the potential to over question, discount, or disbelieve elements of the patient narratives; particularly at times where the organisation or individual staff themselves were being criticised. The nursing experience of the researcher in providing care and treatment to patients in a high secure environment unfortunately encourages questioning, doubt, the seeking of external verification, and to remain aware of alternate motives for disclosure of information.

It was through a reflexive approach that the researcher was able to remain mindful of these issues, however, and of the exaggerated power imbalances that his position generated. Evidence of how these relationships played out during the interview process were identified earlier when discussing researcher identities; a process which demonstrated a transiency of identities by both parties and the potential for such to be self serving at times.

On a practical level these issues and conflicts were examined, explored, and resolved through analysis of the researcher's memo's and field notes, and through the supervisory process. It was this supervision that encouraged and facilitated thought and introspection during the analytical process, and enabled the researcher to inspect and examine the data from a reflexive perspective.

It was this supervisory process that further enabled the researcher to remain cognisant of the potential effects his role and experience may have had upon the inquiry at each stage, allowed for constant questioning of perceptions and judgments throughout the analytical process, and helped shape and determine a reflexive style of writing and reporting. The supervisory elements of the research process facilitated and encouraged introspective thought and examination of the interview transcripts and researcher memo's and field notes, and provided a valuable medium in which ideas, formulations, assumptions and perceptions were debated, challenged, examined and re-examined. It was an important element of the overall reflexive analytical process.

2.6 Study phases

The following part of the chapter discusses the specific phases of the study from pilot through to completion. It should be noted, however, that grounded theory differs from many methodological approaches in that it does not follow the usual linear process of data collection, analysis and interpretation. In grounded theory the constant comparison of data requires the data collection and analysis phases to often run concurrently, with analysis leading to further data collection and again to further analysis until one reaches a point of saturation; the point at which new data gathered fails to further inform or add to the developing categories.

2.6.1 Phase One

The first phase involved the interviewing of both patient and staff respondents. During this phase staff and patient respondents were interviewed regarding either the use of seclusion or special observations. The objective at this stage was to explore respondent's experiences of the interventions from as broad a perspective as possible and to allow for initial coding and subsequent categorisation of preliminary ideas and themes without imposing prejudices or preconceptions on the analysis. This phase allowed for preliminary consideration of the relationships between the categories.

2.6.2 Phase Two

Once preliminary categories had been developed further interviews were undertaken with both staff and patient respondents. This was to both refine the core categories emerging from the initial data collected and to compare the data from these subsequent interviews with that collected in phase one. This comparison of data allowed for saturation; the point at which no further new categories or themes were identified at interview.

2.7 Site selection and participant recruitment

The research site chosen was one of the three high secure hospitals in England, and one at which the researcher held a professional role. This allowed ready and full access to the organisation and potential participants, and offered the opportunity for the researcher to utilise intimate knowledge of the organisation. The researcher was subsequently able to use this prior knowledge within the research process as considered appropriate in adapted grounded theory as advocated by Strauss & Corbin (1990) and Charmaz (2006). It is also noted that the organisation were fully supportive of the research process and provided the researcher with both the time and resources to ensure its completion.

Whilst considered of potential benefit, the issue of the researcher's position required particular precautionary steps; to guard against potential prejudice or preconceptions, and to ensure unbiased recruitment of participants. This was considered important not only from an ethical perspective, but also to ensure data integrity; to ensure that potential participants did not feel coerced or pressured to engage in the study. To ensure transparency a process was devised whereby the

ward nurse managers on each of the high dependency wards were given participant information sheets (see Appendices 1 and 2) that outlined the nature of the study, noted its aims and objectives, informed what would be expected of respondents if they participated, and identified how they could volunteer to get involved. These were then given out to staff and patients who fitted the selection criteria by the ward nurse managers on their respective wards. The potential participants approached were not initially known to the researcher and were only made known if and when the respondents indicated their willingness to participate. This blind method ensured that staff and patients did not feel pressured to participate in research being undertaken by a senior manager. Periodically throughout the research process the ward nurse managers were asked to give out further information sheets as additional participants were required.

As highlighted earlier, the information sheets were only handed to those potential participants who met the inclusion criteria. For staff the criterion was that they had been working in high secure services for a period of twelve months. Whilst this was an arbitrarily set period of time it was considered a substantial enough period for the staff member to have experienced the approaches of seclusion and special observations and to have sufficient exposure to the social and cultural aspects of working within a high secure environment to have been able to develop judgements and opinions of the organisation, the clinical environments, the approach to patient care and specifically to the use of seclusion and special observations. Table 4 below provides descriptive and demographic information relating to both the staff participant group and the nursing population of the research site as a whole.

Patient inclusion criteria was similar to that required for staff participants in that they had to have been resident in the hospital for a period of twelve months; again an arbitrary period, but also considered substantial enough for patients to have developed their own opinions and judgments about the hospital, the care provided, the treatment experienced, and the interventions of seclusion and special observations.

Staff Participants (*n=12*) * *unpublished data supplied by Human Resources Dept – August 2010*		
	Hospital (nursing staff) * (*n=613*)	Sample group (*n=12*)
Gender	Male - 65.7% (*n=404*) Female – 34.3% (*n=209*)	Male – 83.4% (n=10) Female – 16.6% (*n=2*)
Qualified v unqualified	Qualified – 55.3% (*n=339*) Unqualified – 44.7% (*n=274*)	Qualified – 58.4% (*n=8*) Unqualified - 41.6% (*n=4*)
Average Age Age Range	46.8 yrs 21 – 65yrs	43 yrs 28 – 49 yrs
Ethnicity	White British – 61.7% (n=378) Other White – 25.7% (n=157) Black background – 1.07% (n=7) Other/undisclosed – 14.9% (n=71)	White British – 83.3% (*n=10*) Other White - 16.6% (*n=2*)
Average Time in high secure service	Information not available	17 yrs
Range of Time in high secure services	0 - 37 years	4 – 28 yrs
Time on High Dependency wards	Information not available	1-5 yrs - 16.6% (*n=2*) 6-10 yrs - 33.3% (*n=4*) >10 yrs - 50% (*n=6*)

Table 4: Descriptive and demographic data for staff participants

Table 5 below provides descriptive and demographic information relating to both the patient participant group and the patient population of the research site as a whole.

Patient Participants (*n=12*) * *unpublished data supplied by Information Dept - August 2010*		
	Hospital Population * (*n=210*)	Sample group (*n=12*)
Mental Health Act Section	Sec 3 - 9.5% (*n=20*) Sec 37/41- 39.5% (*n=83*) Sec 37n - 11.4% (*n=24*) Sec 47/49 - 31.4% (*n=66*) Other – 8.2% (*n=17*)	Sec 3 - 33.3% (n=4) Sec 37/41 – 16.6% (*n=2*) Sec 37n - 16.6% (*n=2*) Sec 47/49 – 33.3% (*n=4*)
Principal Clinical Diagnosis	Mental Illness – 53% (*n=111*) Personality Disorder – 36% (*n=75*) Neuro-Cog - 11% (*n=24*)	Mental Illness – 58% (*n=7*) Personality Disorder - 42% (*n=5*)
Average Age Age Range	37.5 yrs 18 – 74 yrs	33 yrs 21 – 54 yrs
Ethnicity	White British – 67.8% (*n=143*) Black Caribbean – 6.5% (*n=14*) Other Black – 4.7% (*n=9*) Other – 21% (*n=44*)	White British – 83.3% (*n=10*) Black Caribbean - 8.3% (*n=1*) Other Black – 8.3% (*n=1*)
Average Time in high secure care	6.2 yrs	9.1 yrs
Range of Time high secure care	0 - 30.5 yrs	3 – 21 yrs
Episodes of Seclusion	Information not available	1-10 episodes – 25% (*n=3*) 11-20 episodes - 41.6% (*n=5*) >20 episodes - 33.3% (*n=4*)
Episodes of Special Observations	Information not available	1-10 episodes – 50% (*n=6*) 11-20 episodes - 41.6% (*n=5*) >20 episodes - 8.3% (*n=1*)

Table 5: Descriptive and demographic data for patient respondents

Patients were not excluded on age, diagnosis, gender or ethnicity. Aside from the requirement for twelve month residence, they were required to be capable

of providing informed consent (as assessed by their Responsible Clinician), be conversant in English, and have had experienced seclusion or special observations within the preceding month. This experiencing of the interventions within the preceding month was considered important to maximise the potential for retention of memories and recollection of emotions and feelings. This was a selection criterion for both staff and patient respondents and helped them to recount their experiences whilst fresh in their memory. A final point of note regarding patient participation was the requirement to obtain consent for the patient to participate from the respective Responsible Clinician.

2.8 Description of research site

The research site provides high secure psychiatric provision for a maximum of 228 patients; although normal operating occupancy is 212 (93%) to allow for the potential return of patients on failed trial leaves at medium secure units (who officially remain high secure patients for the duration of the trial leave), for emergency admissions, and for possible Ministry of Justice directed admissions.

The geographical catchment area for the hospital covers a catchment population of around 15 million. Patients are admitted to the service from a variety of health care and criminal justice services. From health care services this is usually from regional medium secure forensic units, whilst from the criminal justice system this is via court, or prison. Patients are admitted for either treatment or assessment, and can be admitted either pre or post trial or conviction. All patients are detained under mental health legislation, with such detention being under civil or criminal sections of the Mental Health Act 2007 (TSO, 2007). The average length of stay for patients within the hospital is 6.2 years, with the average patient age being 37.5yrs and with an age range from 18-74yrs. Patients may suffer from mental illness, personality disorder, or neuro-cognitive deficits, although these are often not mutually exclusive.

The hospital provides a streamed care pathway approach dependent upon primary diagnosis with each mental illness, personality disorder and neuro-cognitive stream providing wards of differing dependency. Dependency in this context relates to the perceived propensity for patients to present violent, challenging or destructive behaviours within the organisation itself. By their nature,

the higher dependency wards use interventions such as seclusion and special observations for the management of violence and aggression to a far greater degree than other wards of lesser dependency, and as such it was these wards that provided the setting from which staff and patient participants were recruited.

Table 6 below provides (unpublished) data for the use of seclusion and special observations recorded over a 6 year period at the research site, highlighting the difference in rates between different ward types.

Research site *unpublished data supplied by Information Dept.*		High Dependency Wards	Medium and Low Dependency Wards
2007	No. of seclusion hours used	136,608	3,336
	No. of seclusion episodes	123	17
	No. of patients secluded	50	9
	No. of special obs hours used	138,416	17,097
	No. of special obs episodes	234	59
	No. of patients on special obs	34	14
2008	No. of seclusion hours used	177,216	2,088
	No. of seclusion episodes	125	15
	No. of patients secluded	57	10
	No. of special obs hours used	168,081	19,365
	No. of special obs episodes	224	72
	No. of patients on special obs	57	17
2009	No. of seclusion hours used	111,240	3,192
	No. of seclusion episodes	155	8
	No. of patients secluded	57	7
	No. of special obs hours used	188,476	14,164
	No. of special obs episodes	177	63
	No. of patients on special obs	64	10
2010	No. of seclusion hours used	143,332	4,095
	No. of seclusion episodes	142	12
	No. of patients secluded	48	8
	No. of special obs hours used	202,101	17,499
	No. of special obs episodes	166	52
	No. of patients on special obs	58	7
2011	No. of seclusion hours used	103,387	5,322
	No. of seclusion episodes	112	17
	No. of patients secluded	47	7
	No. of special obs hours used	198,844	16,024
	No. of special obs episodes	157	48
	No. of patients on special obs	62	8
2012	No. of seclusion hours used	78,574	2.855
	No. of seclusion episodes	174	17
	No. of patients secluded	54	7
	No. of special obs hours used	218,451	21,206
	No. of special obs episodes	144	54
	No. of patients on special obs	55	9

Table 6: Seclusion and special observations by ward type at the research site

For the purpose of this study, and to appreciate the relevance of the data in Table 6, the designations of wards is representative of dependency levels commonly used within the hospital, and are defined as high, medium and low dependency. High dependency wards provide care for those patients who require

considerable levels of care because of the chronic debilitating effects of their ensuring mental illness or as a result of their continuing propensity for violent or destructive acting out behaviours within the hospital setting. Medium dependency wards are those in which patients display a greater degree of self care skills, are less prone to adverse acting out behaviours, and are often engaged in offence focused and skills deficit treatments. Finally, low dependency wards are those in which patients display high levels of self care skills, have undertaken much of their offence focused treatments, and are often engaged in long term rehabilitation aimed at moving out of high secure care.

From the data in table 5 it is evident that there are clearly more seclusion episodes and individual patients secluded in the high dependency areas. Similarly, whilst the hospital recording systems currently fail to differentiate between the use of special observations for the management of potential violence and aggression or for those presenting a risk of self harm, there is evidence that the practice in general is used to a far greater extent in the high dependency areas.

2.9 Overlap in practice

As highlighted in the previous chapter on seclusion and special observations, it is common practice at the research site for patients subject to a seclusion episode to experience periods outside the locked seclusion room whilst supervised and supported by nursing staff; allowing for assessments of risk and mental state prior to termination of the seclusion episode. In essence this practice can be seen to be similar to special observations, in that there is the assignment of specific staff to constantly observe and support the patient, even though he remains subject to the restrictions and requirements of the seclusion episode and the policy guidance that governs its use. This potential overlap in practice is significant to note from a research perspective, however. Throughout the data collection and analysis processes it was important to ensure that researcher and respondents were both able to recognise and identify which intervention was actually being discussed and described; with this being achieved through questioning and reaffirmation of information during the interview process, and through reflection in supervision sessions. As highlighted earlier, this was considered important to ensure that any differences or similarities in experience or

opinion between the practices could be elicited without potential contamination or confusion about which practice was being discussed or described.

2.10 Interview procedures

The following section provides a description of the interview process and procedure adopted for the study. As previously highlighted, potential respondents approached the researcher; either directly in the case of staff participants or via their respective ward nurse managers in the case of patients. At this stage a mutually convenient time and venue for interview was arranged. Staff interviews were undertaken either within the clinical area in which they worked or in the researcher's office, with the respondent choosing preference. With patient participants the venue was always the ward environment as this proved easier to arrange from a logistical perspective.

Interviews in the first phase were undertaken based upon a semi-structured interview schedule (see appendices 3 & 4). These served to maintain a degree of structure to the process, and ensured areas identified as being of potential interest and relevance were discussed and explored. However, they still provided opportunity to allow for free flowing discussion and expression of experiences, perceptions and recounting of events from the respondent's perspectives and frame of reference. They allowed for investigation without confining data to preconceived categories or themes either proposed or imposed by the researcher, offering scope for respondent directed discussion, and allowing for comparison of data from earlier interviews as the study progressed.

The interviews during the second phase of the study did not follow the semi-structured interview schedule, but were more concentrated and focused in direction to allow for the refinement of initial themes that had emerged from the data collected and analysed in the first phase. This allowed for comparative analysis to establish and refine core categories.

Prior to interview commencement all participants were required to sign consent forms, with patient forms providing the additional consent for access to clinical notes. This was followed on commencement of the interviews with reassurance about confidentiality with some specific caveats. With staff

respondents this was that any disclosure of serious unprofessional conduct may need to be reported, and with patients that any expressed intent to harm either themselves or others would be reported to their respective care team. This was considered important in that whilst participating in these interactions as a researcher, professional responsibilities and codes of professional conduct would continue to dictate disclosure of any such behaviour or proposed actions.

Whilst no respondent withdrew from the study, affirmation was given to its voluntary nature and the ability to withdraw their participation at any stage, either during or post interview. Participants were also reassured that the tape recordings of the sessions and subsequent transcriptions would not be divulged to any person within the hospital and that their safe storage and disposal was guaranteed. In all, there were 24 participants in the study, 12 staff and 12 patients. Each was interviewed once and the average duration of interviews was 72 minutes.

Following interview, the tape recordings were transcribed by the researcher himself and memo's taken regarding thoughts and views on the content of the interview. These were later used to reflect upon the interview and assisted in ensuring objectivity within the transcribing and data analysis processes.

2.11 Analytical process

The following section describes the analytical process, emphasising the distinct stages of data analysis and interpretation that occur within a constructivist grounded theory framework. It will highlight the differences between the different coding stages and their inter-relatedness within the overall research process. It will demonstrate how grounded theory coding allows for the shaping of "an analytic frame from which you build the analysis" (Charmaz, 2006, p45)

2.11.1 Initial coding

The first stages of coding is where the data collected is analysed section by section, line by line and even word for word. It is from this micro level of interrogation that the researcher is first able to ascertain and subsequently describe what is occurring in the respondent's narration of events and start to think and reflect about meaning. Charmaz (2006) notes four specific elements of this initial thought; notably that one should question what the data is a study of, that

one should consider what the data is suggesting, that one should question from whose perspective this is suggested, and finally into what theoretical category does it indicate.

This stage of coding requires the researcher to remain open to ideas and not attempt to place the data into preconceived categories. It is from the identification and subsequent comparison of these codes that fine distinctions between data is noted, and from which preliminary categories are constructed that represent the understanding and meaning of events and issues from the participant's perspective and frame of reference. It is at this stage of coding that conceptualisation starts to occur and ideas about future direction can emerge.

2.11.2 Focused coding

Following from this initial stage the coding becomes more discerning and focused. It is at this point that the attention moves from micro-level analysis towards the macro; the analysis of larger sections of data and consideration of how the codes identified in the initial stage relate to each other to form categories.

It is the stage that decisions are made as to which codes and subsequent categories are the most relevant; developed through the constant comparison of earlier data. Focused coding allows the researcher to move from initial description towards explanation and conceptualisation. It is about immersing oneself in the data and moving from passive describer and analyst to active interpreter. Examples of this focused coding are given below in Table 7.

Analysis and subsequent grouping of these initial themes allowed for the development of broad low level categories. With the patient participants this included the perception of the high secure system as staff centred, corrupt and controlling, and giving rise to both passive and active survival strategies to combat the stressors and threats encountered and the relationship of these strategies to aiding or hindering their perception of progress.

Patient participants	Staff participants
Overt and covert control	Pressure to conform
Coercion	Increased accountability detracting from care
Negative staff attitudes	Confusing messages to new staff
Abuse of power	Policing of practice
Use of retaliatory violence	Pressure to reduce seclusion
Use of pre-emptive violence	Balance between security and treatment
Contemplating future	External scrutiny & questioning of practice
Reflecting on past events	Organisational support post incident
Avoiding violence	Culture change putting patient at centre
Progress planning	Physical restraint as last resort
Others progressing quicker	Conveying confidence to allay fears
External control over detention	Safer place to work
Indeterminate detention	Fear for own safety
Discrimination and victimisation	Feeling intimidated
Punishment	Anxieties
Inconsistent staff approaches	Frustration and disappointment
Unwarranted use of restrictive practices	Pt unpredictability
External supports	Concern over decision making
Self isolation	Over assessing risk when frightened
Positive staff attitudes	Patient loss of identity
Self determination	Seclusion often the easiest option
Playing the game	Winning hearts and minds
Lack of control over rate of progress	Humour and warmth
Unrealistic temporal expectations	Investing of time and effort
Awareness of lack of progress	Seclusion as protective function
	Attitudes of colleagues
	Building trust
	Folklore and reputations
	Seclusion as therapeutic
	Overcoming own fears and anxieties
	Changing perceptions

Table 7: Initial themes from focused coding

An initial graphical representation of the patient categories identified through this process of focused coding can be seen in Figure 1 below.

Focused coding of the data from the staff participants allowed for the development of categories that influenced their ability to survive the stressors and threats faced in the provision of care. These included elements of the high secure system itself, relationships and interactions with peers and colleagues, relationships and interactions with patients, and responses to disturbed behaviour.

An initial graphical representation of the staff categories identified through this process of focused coding can be seen in Figure 2 on page 98.

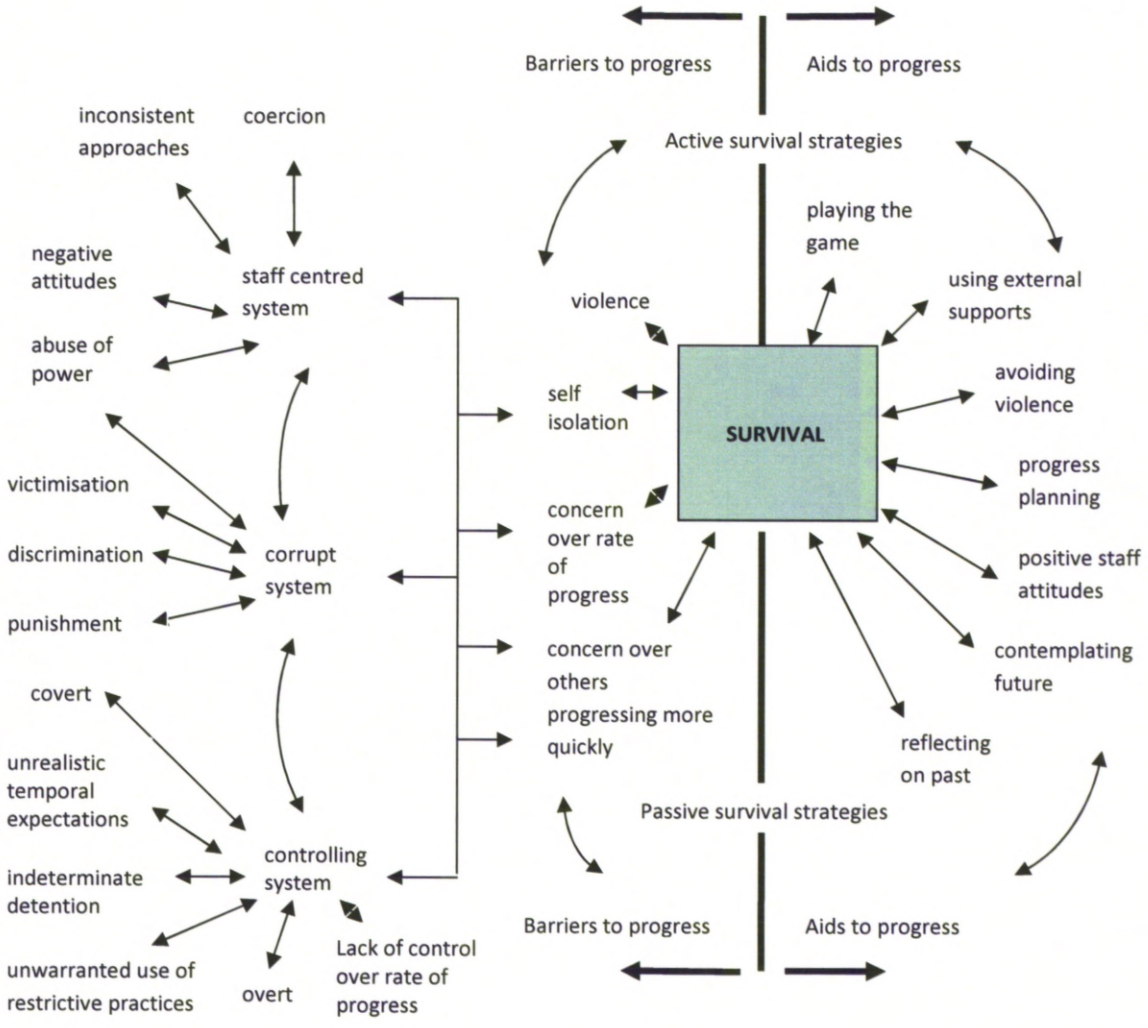


Figure 1: Initial graphical representation of patient categories

2.11.3 Theoretical Coding

Theoretical coding represents the final stage of coding. It is at this stage that the relationships between categories established during focused coding are more clearly identified. It is the point at which the researcher begins to conceptualise and theorise as to how the categories relate; the point at which one moves the analytic story "in a theoretical direction" (Charmaz, 2006, p63).

This stage of coding allows for sharpening of preliminary analysis, strengthening of concepts, clarification of major and sub categories, and comprehension of their relatedness.

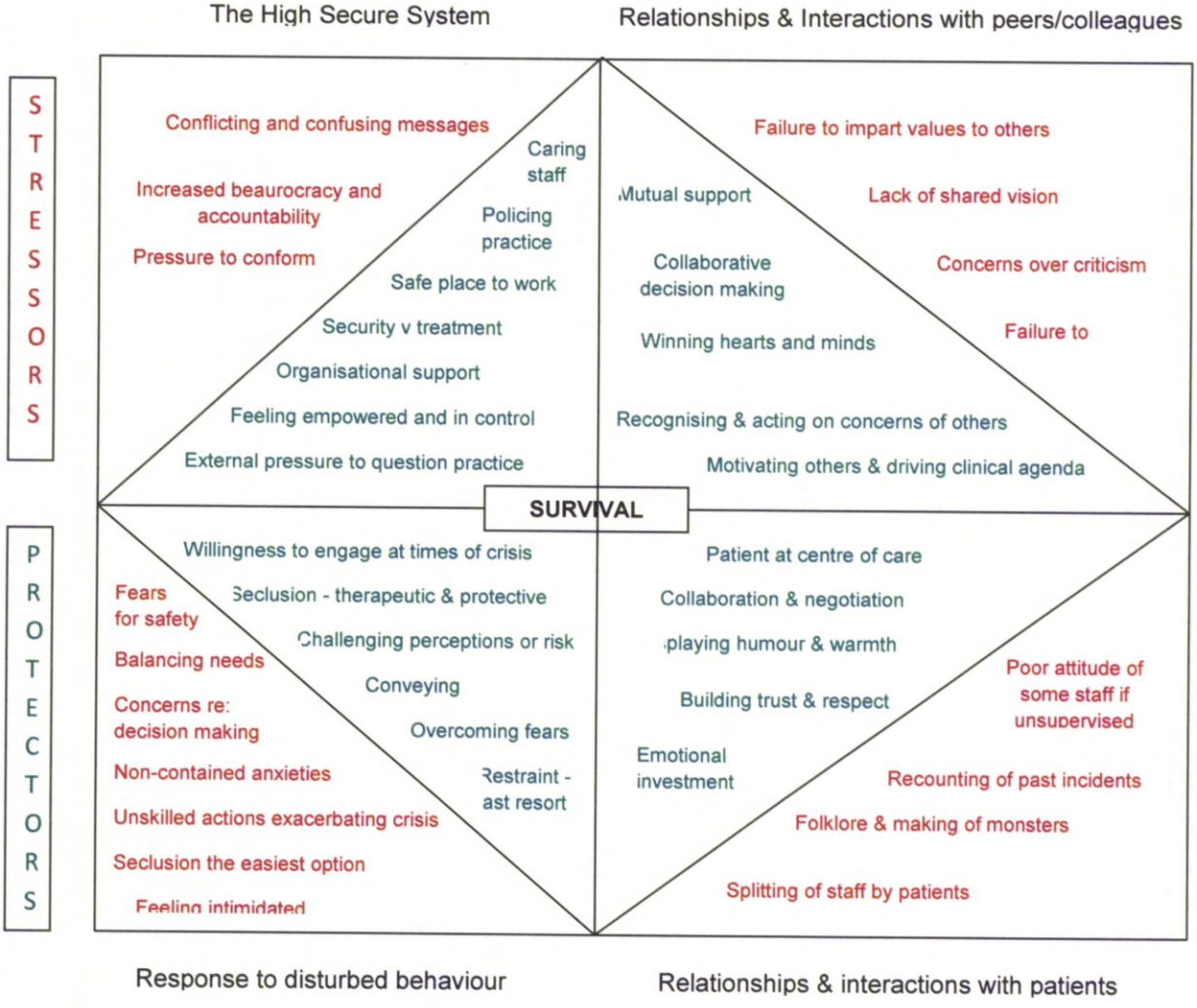


Figure 2: Initial graphical representation of staff categories

2.11.4 Data management

Semi-structured interviews can generate vast amounts of data, with a single interview capable of producing several hundred preliminary codes. To prevent becoming overwhelmed by the line by line and word by word coding process required at the initial stage there was a need for an effective system of data management; there being a clear difference between immersing oneself in the data and being overwhelmed by it.

This data management was provided by the use of NVivo v8.0 computer software. This program allowed for the recording of preliminary codes ('free nodes') in the initial stage (see appendices 7 & 8) and of categories ('tree nodes') during the later stages. Whilst having the ability to assist in modelling and graphical representation of categories and relationships, the program was not used to analyse the data or to draw conclusions or interpretations from it; the program

remained a management rather than analytic tool. The program did, however, offer clarity in the recording of data, proved a system for easy data retrieval, and ultimately provided a sense of order when faced with the large quantities of information generated from the interviews.

2.12 Methodological rigour

There were several safeguards incorporated into the study to ensure methodological rigour, including ethical considerations, reflexive practice, supervision, and supervisory verification of the data collection process and subsequent analysis and interpretation.

Ethical approval was obtained from the Local Research Ethics Committee prior to the commencement of the study, together with approval from the Research Governance Committee of the research site itself (see appendix 5). Throughout the study the reporting and monitoring requirements of both the ethics and research governance committees were satisfied, as were the requirements of the University of Liverpool and of the external funders of the study; the National Forensic Mental Health Research & Development Programme. These continuing reporting and monitoring arrangements introduced safeguards and provided assurances that the procedures undertaken were based upon recognised and approved principles of health care research.

From a researcher perspective the use of memo's throughout the study offered opportunity to reflect upon objectivity and potential influence upon the data and its interpretation. This reflexivity allowed for questioning of researcher positionality and potential bias. An integral part of constructivist grounded theory, this awareness of one's own interactions with the participants allowed for reflection, contemplation, and questioning of process validity and methodological robustness.

Further safeguards to maximise rigour were provided through regular supervisory sessions. These provided opportunity for questioning of both procedure and outcomes; to challenge preconceptions and values that may have been placed upon the data and to review progress as the study moved from the collection, through to analysis, and ultimately to interpretation.

CHAPTER 3 – FINDINGS

Part One: The patient experience

3.1 Introduction to the findings

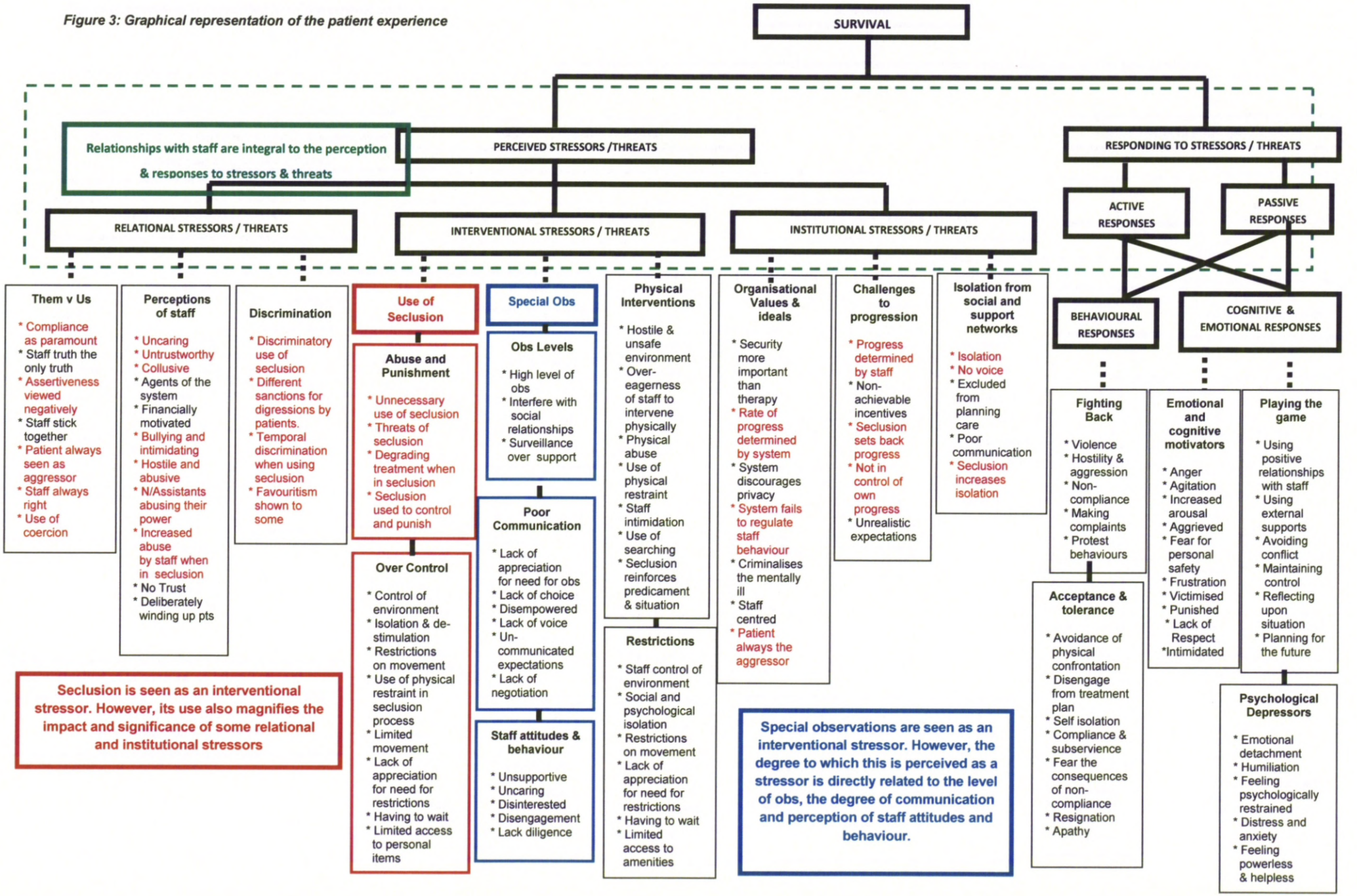
This part of the chapter discusses the findings from the data collected on the patient experience of seclusion and special observations, presenting an interpretive theoretical framework that reflects these experiences and meanings from the patient's perspective. It highlights the challenges faced by patients in coping with the stressors and pressures present within an environment they often consider biased and disempowering and, through examples from the data, illustrates the cognitive and behavioural processes often utilised by patients to survive these perceived threats and hazards.

The chapter will demonstrate how the theoretical framework was established from the initial coding and categorisations; showing how concepts were derived from the grounded data through focused coding and constant comparison of information, and subsequent identification of relationships between themes. The chapter will continue by comparing and contrasting this theoretical framework of patient survival to established theory of survival in institutions; namely that of Goffman (1961).

3.2 The theoretical framework

The theoretical framework that explains the patient experience is that of survival. A graphical representation of this can be seen below in Figure 3. The patient experiences demonstrate how they perceive threats and stressors in their environment and how these perceptions elicit responses aimed at providing physiological, cognitive or emotional protection from these antagonisms. In responding to these perceived stressors and threats, however, it is noted that there appears to be a tendency for patients to focus on real time protection at the expense of longer term adaptations. That is to say the immediacy of the need for self protection often appears to outweigh consideration of the long term consequences of actions or behaviours. Many of the annoyances or antagonisms the respondents experience appear present in their everyday lives within high secure care, and are often associated with interactions with staff,

Figure 3: Graphical representation of the patient experience



situations encountered, or restrictions within the clinical area. How these are perceived, however, appears to be closely related to their relationships with staff. It is the nature of these relationships that can influence the degree to which patients consider these everyday annoyances and antagonisms to be stressors or threats, and how they subsequently respond emotionally, cognitively and behaviourally. These perceptions and subsequent responses are often influenced by pre-conceptions held about staff motives and intentions; pre-conceptions based upon previous interactions and established relationships. These include perceptions as to whether nursing staff are generally benevolent or malevolent in their approaches, and whether or not they consider staff to be justified or fair in their approaches in the specific conflict situation in question.

The following sections highlight the core categories that are central to the concept of survival. Detailed description and discussion of the lower level categories illustrate how these core categories emerged from the data to establish the theoretical framework shown in Figure 3 above. This part of the chapter is divided into discussion of the two core categories underpinning the concept of survival; namely the perception of stressors or threats and the response to these (see Diagram 1 below). The description and discussion of each core category is supported by evidence from the lower level categories whose inter-relationships helped establish the higher and core categories. These supporting categories composed of broad related themes and concepts that were derived from the raw data.

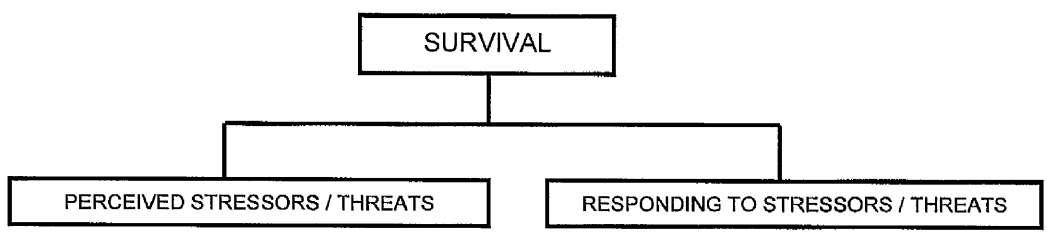


Diagram 1: Patient core categories

It is noted, however, that there was a degree of inter-relatedness and overlap evident when grouping themes together, when establishing relationships between them, and when subsequently developing a hierarchy of categories illustrative of the core concept of survival. Notably, it was evident from the

narratives that there was a relationship between the perceived threats and responses to the interpersonal relationships patients hold with staff and their perception of staff motivations; that the role of seclusion in magnifying the perception of threat; and the general differences in perception between the use of seclusion and special observations. These relationships will be explored in detail in the forthcoming sections, together with the similarities and differences in perceptions and experiences of seclusion and special observations both within and between the patient and staff participant groups.

3.3 Perceived stressors / threats

The first core category established was that of 'perceived stressors/threats'. This category illustrates how the respondents experience pressures not only in their everyday life within the hospital, but particularly at times when they perceive a specific injustice or frustration, or when a conflict situation arises with staff or other patients. These stressors and threats were categorised as relational, interventional and institutional (see Diagram 2), and represent differing perspectives upon the pressures faced within an environment they perceive can be hostile, over controlling and abusive.

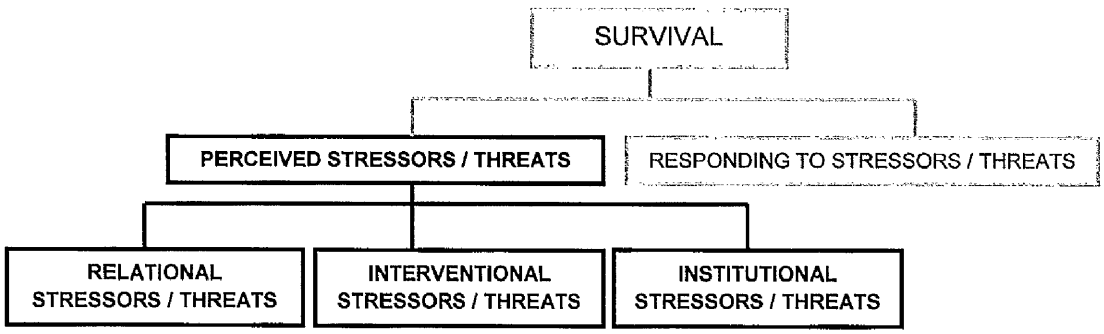


Diagram 2: Categories of perceived stressors/threats

The following sections will explore each of these categories and supporting sub-categories, illustrating their relatedness to this central phenomenon of survival and the relationship to the practices of seclusion and special observations.

3.3.1 Relational stressors / threats

Relational stressors and threats are those that arise as a result of specific interactions with staff on a day to day basis. They are the interactions that arise that can lead to conflict, frustration, anger and feelings of helplessness. They are those that compound the disempowering nature of the patient relationship with staff and the system in which they find themselves. Supporting lower level categories were identified as 'them v us', 'perceptions of staff' and 'discrimination' (see Diagram 3); each comprising of their own specific themes. These will be discussed in detail to illustrate the nature of how patient participants perceive their interactions with staff within this high secure psychiatric setting.

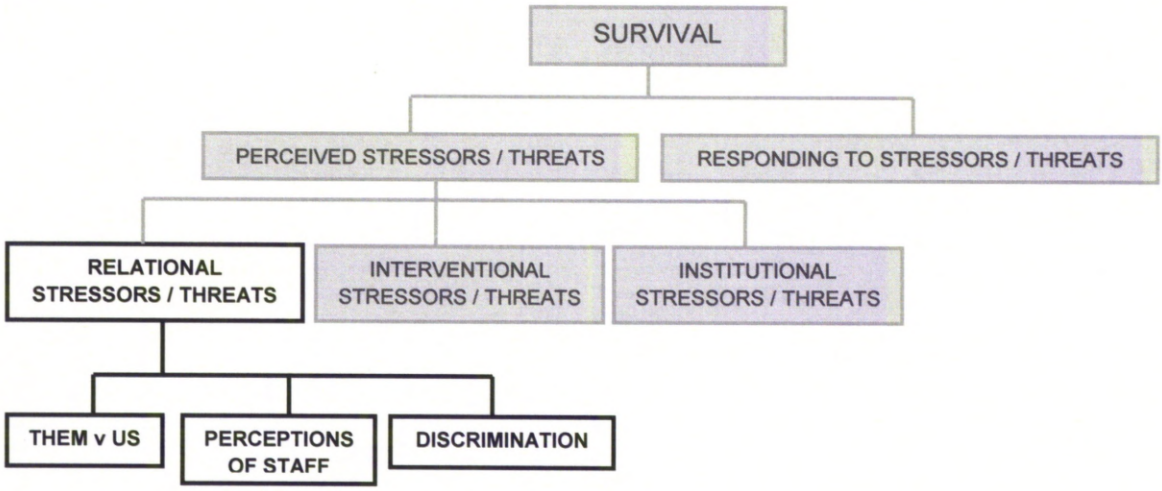


Diagram 3: Sub-categories of relational stressors/threats

Them v Us

Many of the patient respondents spoke of a 'them versus us' culture existing within their interactions with staff. They recognised the power imbalance that exists between themselves and staff and how it is often a struggle to be heard and listened to by staff who they perceive as always considering themselves to be right and advocating their truth to be the only truth. This point was highlighted by several respondents when noting:

> *"I was putting in complaints, right, because they was writing marks on the computer. So I was putting in complaints so people could hear my side of the story, right; and my side of the story is the true side of the story."* (PR1)

> *"The one thing I don't like is when you get someone in charge and they know the nurse is wrong and because he's a staff they will stick together and say you're still wrong. I'm always wrong."* (PR2)

This introduces the concept of collusion amongst staff and appeared to be of concern to many of the respondents. They noted how they believed staff would always stick together and support one another irrespective of the validity of their argument or point of view. This was highlighted by a further respondent when commenting:

> *"He's their team leader, so they act the bollocks, 'cos he's going to cover for them all the time. You know?"* (PR5)

This perception of a cultural and social divide between staff and patient groups; the them v us, was evident in some of the patient narratives when they spoke about their experiences of special observations, with comments such as

> *"they just watch you don't they, they don't talk to you much. We aren't good enough to talk to apparently"* (PR9)

> *"its them in the staff chairs and us in the middle mostly"* (PR10)

This perception of staff colluding, their sticking together, appeared to reinforce the perception of a 'them and us' culture and would compound the stressors faced by patients. Respondents often saw themselves trapped in a system in which they were indefinitely held, where the staff could determine what was written about them, would determine whether they progressed or not, and, on an everyday level, were able to control many aspects of their daily life. Respondents would also talk of how this control was exerted through an expectation of compliance, and how at times they felt coerced into complying with staff requests if they were to progress:

> *"if I didn't take the tablets they wouldn't have let me out of seclusion. They wouldn't have let me out of seclusion if I hadn't taken the tablets. How much tablets a doctor wants me to take I had to take it."* (PR2)

The data suggested that patients would often perceive this expectation to comply with requests and directions to occur within the parameters of interactions with staff in which they feel unable to challenge without consequence, to articulate opinion without their assertiveness being held as aggression, and where they are

always considered the aggressor in any dyadic encounter; regardless of intent or action. This expectation in itself appeared to compound feelings of frustration and helplessness, and restricted potential outlets for patients to express any frustrations or anger that arose as a result of their perceived position in their relationships with staff. This notion of staff seeking compliance is discussed further when considering the findings from the staff narratives where it is seen as a significant motivator for staff in their attempts at maintaining control.

Perceptions of staff

Perceptions of relationships with nursing staff varied considerably and appeared to be correlated with the respondent's overall attitude towards their care, treatment and confinement. Some respondents articulated a reasoned, almost reflective narrative about their care and their relationships with staff:

> *"there are some staff who have a laugh with me, and there are some good staff like who really help me out like."* (PR7)

Others, however, were almost acerbic in their dislike, mistrust and hostility towards some staff, with their animosity often reflective of their perception of the hospital and the care process as a whole. One particular respondent demonstrated a severe dislike of some staff, perceiving them to be deliberately provocative and abusing of their position. Examples of his perceptions included:

> *"But xxx is a bit of a cunt mate and that's the truth. That is the truth, you know? Er, he winds me up. He made me smash my room up didn't he? When I was in the box [seclusion room] there he came down acting the bollocks wanting to search me and all that."* (PR5)

> *"it's not me, its them that come the bollocks with me, you know. And they expect me to back down."* (PR5)

> *"they are piss takers mate, they basically think they are three fucking hard men, you know?, Er, they just think they are fucking hard men. You know? I'm telling you the truth Des they should be struck off mate. And that is the truth."* (PR5)

These responses were consistent with the overall impression that this respondent held of the care and treatment he was receiving and of the system of high secure care. It is also supportive of the theory that perceptions about the

nature of services provided and perceptions of the approach, attitude and motivations of individual staff can be related at times.

This link between how patients perceive staff and how they perceive their care and treatment also held true for the other respondents; some of whom expressed less extreme opinions on both care and staff, however. These respondents appeared to acknowledge individual differences in approach and attitude between staff, noting:

> *"to some degree, some degree, depends on the staff really. If the staff like you they will help you. If they don't like you they'll give you a hard time."* (PR1)

> *"some the staff are better than others. Some really listen to you and want to help; others don't give a fuck."* (PR8)

Whilst views of individual staff varied amongst respondents, a theme that did emerge was the perception that some staff had a tendency to deliberately provoke patients and display uncaring attitudes towards them; even to deliberately provoke at times. Respondents noted:

> *"To become nurses Des, it's not about winding people up and fucking playing silly games with them. It's not about that Des. You become a nurse to help them, right? Whichever way they need help you are there to help them. You know, not act the bollocks. You know?"* (PR5)

> *"he done it deliberately, you know? He was trying to get me going, to lose it, yeah? Fucking spiteful that was."* (PR1)

They also noted that at times they felt staff would abuse their position and want to exert unwarranted power and control. This was particularly evident in respondent perceptions of nursing assistants. Several of the patient participants spoke of how they believed nursing assistants would often seek to exert power and authority over them, deliberately provoke, and at times display negative attitudes towards them. Whilst these perceptions of nursing assistants were evident in the respondent's everyday hospital life, the influence held over them by this group of staff was considered to increase at times they were subject to restrictive practices such as seclusion. Examples of this concern included:

"you get the one or two people, the NA's and they want a bit of power like, and they'll go out of their way to try and get a bit of power." (PR2)

"You know they get to play God basically, you know." (PR4)

Interestingly, however, was the noticeable change in perception of Nursing Assistants when assigned to special observations. Here several of the patients spoke of how it was this group of staff who would spend more time engaging with them, noting how qualified staff were more likely to disengage and remain distant. This was illustrated with comments such as

its good when xxxxx, xxxxx or xxxxx are on obs 'cos they'll muck in and do stuff with me" (PR12) "

"the qualified just want to sit in the office and leave us alone" (PR2)

Other perceptions of staff in general included the belief that some were untrustworthy, financially motivated, and merely agents of the high secure system. At times some respondents would articulate difficulty in accepting staff approaches as being genuine and without ulterior motivation, noting:

"It's because they don't tell the truth Des, they don't tell the truth." (PR4)

*"I don't trust that xxx, he has always had it in for me ever since I was on **** Ward. He's two faced, all smiles to my face but then writes crap on the computer about me."* (PR3)

This suggested that some patients had difficulty in establishing trusting relationships with some staff and held negative perceptions of them and their intentions. Further to this, however, some respondents perceived the approaches of staff to be uncaring, abusive, disrespectful, and even hostile at times. Some of the narratives indicated the view that particular staff could be deliberately intimidatory and bullying towards patients, noting:

"one staff was really talking arrogantly towards me, you know?, disrespectful like. I watched the way he would speak to the staff and the way he would speak to the patients and, er, I didn't like it." (PR2)

Others spoke of how on occasion staff would use their physical presence to deliberately intimidate, highlighting:

> *"he would swing his keys near me and walk very close to me."* (PR1)

Yet another articulated how they perceived staff to have deliberately bumped into them in an attempt to provoke:

> *"I walked out of the ECC meeting and xxx fucking banged into me in the left hand shoulder. I didn't see him do it but he was the nearest one to me...he either pushed into me or banged into me in the shoulder."* (PR5)

Others still would note how some staff would present as bullies, but failed to articulate rationale to back up their perceptions:

> *"Sometimes xxx can come across as being a bit of a bully."* (PR4)

Discrimination

This perception of increased intimidation and abuse of patients whilst they are subject to a seclusion episode is also associated with the view that seclusion itself is used in a discriminatory manner. Respondents were of the belief that favouritism can often be shown to some patients over others, that on occasion there appears to be different sanctions applied to patients for similar digressions from what staff perceive as accepted behaviours, and that the duration of seclusion episodes are routinely dependent upon individual relational factors rather than being clinically based.

This issue of discrimination, not only in the use of seclusion, but also in the use of special observations and everyday hospital life, is supported by several of the patient narratives who perceive some staff to deliberately single them out. Examples included:

> *"I'm singled out on the ward and can't go to another ward after being locked up on one ward for four years."* (PR9)

"what I don't like is if there's an interaction between me and another geyser they'll tend to grab me in a bad way, and box me [seclude] and not box the other geyser." (PR7)

"it just doesn't seem fair sometimes Des, you know what I mean?, whenever I'm put on obs there's at least two of them and I'm always down the bottom [night area of ward], but others are just allowed to wander around" (PR8)

Other respondents noted:

"Like for instance, suppose you go in there [seclusion], like some patients will go in there for one night and then they'll come out the next day. I've had an incident where I was grabbed by a staff and I defended myself and I was in seclusion seven weeks. I've seen patients hit a nurse in the head and he is out the next day." (PR2)

"how come I can spend weeks on obs when others get it for a day? (PR1)

Not only does this indicate that some patients felt discriminated against with regards to the use of seclusion and special observations, but the narratives also suggested that at times the perceived level of injustice and discriminatory attitudes of staff was related to their overall perception of staff behaviours and justifications.

Throughout the narratives it was evident that the general perceptions of staff and their motivations appeared to vary from patient to patient. Some respondents clearly disliked many of the staff with whom they came into contact, and ultimately conflict. Others, however, appeared to have a more varied and less explosive or antagonistic relationship with those tasked with providing their care. Whilst those patients who disliked staff would also express disdain and dislike of the treatment and care they were receiving and of the organisation itself, others appeared more selective in that they would recognise the positive attributes and intentions of many of the staff and generally respond positively to these in their everyday encounters with them.

Of note, however, was how these positive relationships appeared fragile at times; particularly at times of intense interpersonal conflict such as during seclusion or special observations. At such times these positive relationships would

often be side-lined with the brunt of the patient anger or frustration being directed towards staff. One patient noted

> *"I usually get on alright with xxxxx, but when he's on my obs he doesn't talk to me, so I think fuck him !! "* (PR7)

3.3.2 Interventional stressors / threats

The second main category supporting the core category of 'perceived stressors/threats' is that of 'Interventional stressors/threats'. These are those pressures and threats that arise as a result of actual or threatened specific staff interventions. These include the use of seclusion and special observations, as well as general restrictions and other physical interventions such as physical restraint or searching (see Diagram 4).

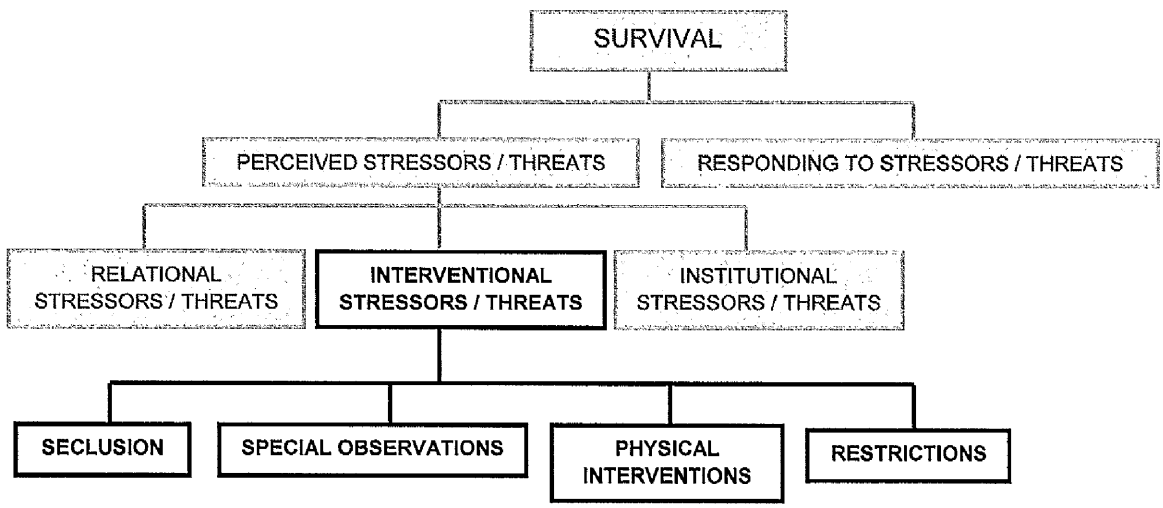


Diagram 4: Sub-categories of interventional stressors/threats

It relates to those times when staff may exert control, restrict access to items or amenities, or act in such a way that patients perceive an imposition, or threat of imposition, of a restrictive practice such as those of seclusion or special observations.

They are those stressors and threats that go above and beyond the normal restrictions present in the respondent's daily hospital life, and are seen as potential sources of interpersonal conflict that can significantly impinge upon activities of

daily living or progress through the high secure system. They are those incidents of conflict that can elicit extreme protective responses.

Seclusion

Respondents considered seclusion to be an interventional stressor, at times noting it to be particularly abusive, punitive and over controlling. Of significance, however, was that the same respondents would also articulate therapeutic benefits to its use at times; benefits that will be discussed later when exploring the patient responses to threats and stressors.

Primarily an interventional stressor/threat, seclusion was also noted to have the propensity to magnify the impact, and increase the significance of some other relational and institutional stressors and threats. The data suggested that patients in seclusion would often become more acutely aware of other stressors and antagonisms present in their everyday lives, with seclusion itself often amplifying the feelings of disempowerment, and pressure to conform and comply. It would heighten perceptions of discrimination and victimisation in a care system they already perceived as alienating and marginalising.

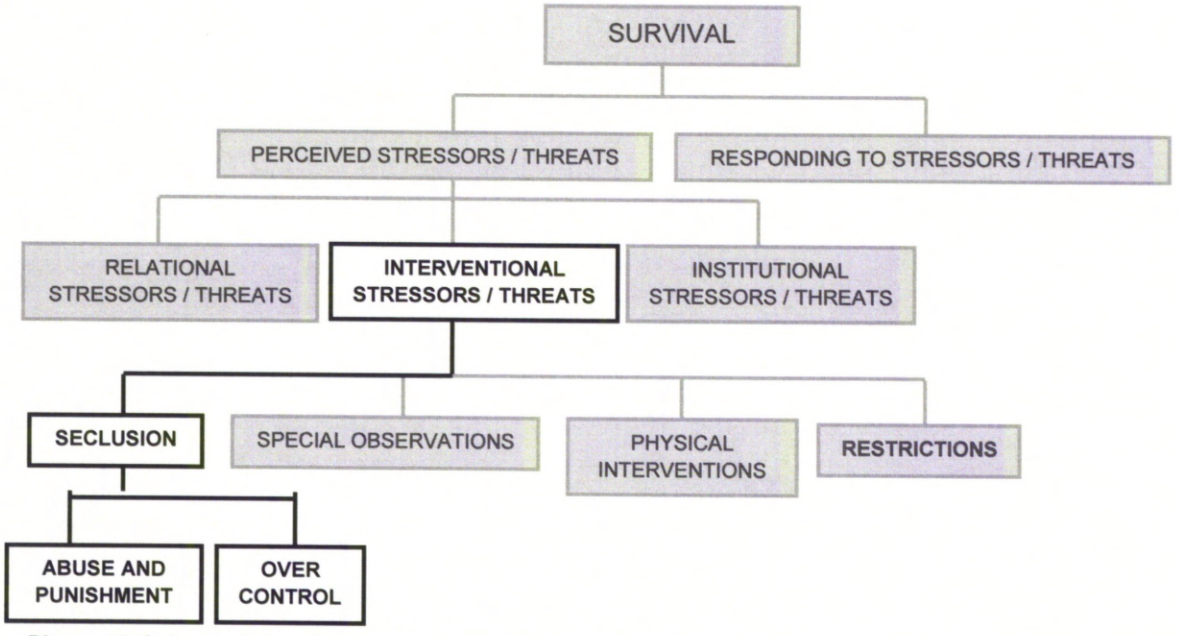


Diagram 5: Sub-categories of seclusion as an interventional stressor/threat

As an intervention in its own right, seclusion was often seen by the respondents as an ever present threat against staff determined normalcy; as a tool

to gain and maintain compliance and control, and an intervention with which to punish and mistreat. It was often perceived as a means of maintaining dominance over patients and one that reinforced the helplessness of their situation through abuse, punishment and over control (see Diagram 5).

Abuse and punishment

Abuse and punishment was identified as a sub-category of seclusion as an interventional stressor/threat. Several of the respondents spoke of how it was used unnecessarily at times and how staff would initiate it when they believed less restrictive interventions could have ameliorated the conflict and resolved the situation or incident. These respondents would often blame the staff for over-reacting, of intervening too early with restrictive practices such as seclusion, or of extending the use of such restrictive approaches beyond their need. An example of its perceived unwarranted use can be seen in the following example from one respondent who spoke of how an altercation with staff led to his being secluded:

> *"They said I looked like I was going to hit them, but I'll tell you straight, if I had wanted to hit them, they would have fucking known about it. I admit I was angry, but they should have just left me alone in my room; they pushed and pushed."* (PR8)

Another respondent spoke of his belief that he could have moved to a less restrictive environment quicker than he did; considering the length of time spent in a seclusion room to be a deliberate attempt at punishing him:

> *"I think it was in a way like to punish me, like, because they could have moved me back to my room a long time ago and kept me in seclusion there. But they kept me in a strong box more, more than what I spent in my own room. I spent like 4 weeks in seclusion in the strong box then 3 weeks in my ordinary room."* (PR2)

Yet another respondent spoke of how he was secluded as a means of punishment following an altercation which he was falsely accused of threatening staff:

> *"They said I had been put in seclusion because I was threatening. I wasn't threatening. They use it as a means of punishment don't they?"* (PR5)

Not only would this suggest that the patient was of the belief that seclusion was unwarranted, it clearly engendered a high degree of concern and anger, as evidenced in his following statement:

> *"Now I'm telling you Des he was straight in the line for a straight right. I could have took the head off that fucking cunt mate. Er, and me personally I think he would have gone out like a light."* (PR5)

It was clear from these narratives that the respondents felt aggrieved by seclusion and the ulterior motives they perceived to be influencing staff in its use. However, it was not just the unwarranted use of seclusion that appeared to be a stressor for patients, with several claiming that they had been threatened with its use in what they perceived to be attempts by staff at maintaining control and compliance and as a means of further punishment. Respondents commented:

> *"I have been threatened with seclusion, yeah, been told if you don't shut up you'll be in the box."* (PR2)

This was also evident in some of the patient narratives around the use of special observations, although to a lesser degree. Whilst there was evidence of being an antagonism, patient concern about unwarranted use did not appear to elicit the same level of anxiety or animosity than seclusion. One patient stated

> *"sometimes they'll put you on obs just for the sake of it, you know to piss you off like. Them cunts like winding you up [laughs]"* (PR5)

In their professing of opinion on the punitive aspects of seclusion, however, some respondents would offer detail of their personal experiences, whilst others would merely state opinion. Those who recounted events spoke of their concerns over such issues as environmental conditions and imposed restrictions; one noted:

> *"you are made to wait for everything. They take their time in dealing with you, they are always saying 'you'll have to wait for this or wait for that. I think they do it on purpose sometimes just to punish you."* (PR1)

whereas those who would simply offer opinion would offer comments such as:

"It's a psychological way of punishing you." (PR8)

"you can use seclusion as, erm, a form of punishment, but they don't put it that way." (PR6)

It was clear, therefore, that many of the patient respondents considered the intervention of seclusion to be punitive in its implementation. Patients would note the disparity in it use between different patients, highlighting how some patients would be treated differently to others:

"If you check me, my clinical notes, you'll find out for yourself that I've been in seclusion for minor things and if you check the other patients' notes you'll find that they have done things and they haven't been in seclusion." (PR3)

What was also evident from these narratives was that those patients who perceived staff to be abusive, disrespectful, intimidatory, provocative, or wishing to exert unwarranted control, would note an exacerbation of these behaviours whilst they were subject to seclusion. They considered seclusion to provide these staff with the opportunity to display such behaviours without being held to account. One respondent with a particularly poor perception of staff attitudes and motivations, as highlighted earlier, talked of how staff would deliberately wind him up when he was in seclusion, noting:

"So I said to him 'why do you always wind me up when the door is locked?' and he says to me why do I always shout at him when the door is locked. So I say to him 'well open the fucking door and we'll see who's fucking shouting, you prick, right?" (PR5)

This respondent found the approaches of staff to be provocative and deliberately malevolent in intent. However, a further respondent similarly spoke of an incident that occurred whilst in seclusion. This particular respondent recalled an altercation with staff that occurred whilst subject to a period of assessment outside the seclusion room that resulted in physical restraint and a return to the locked seclusion room:

"I was speaking to him nicely and he was speaking to me, erm, disrespectful again, so I said to him "I talk to you with respect you should speak to me with respect'. I did point at him like and he turned round and went to grab me in a violent way. So I punched him because I knew he shouldn't be doing what he was doing to me. So I punch him and they all jumped on me and they put me back in the strong box." (PR2)

It was evident from the recounting of this incident that the patient felt not only disrespected, but also that staff were unjustified in using physical force and that this was deliberately provocative. It was clearly an incident that gave rise to considerable concern to the patient.

Perceived inconsistency in the consequences for digressional behaviours appeared to be of some concern for patients. A common theme within the narratives was the wish for equity, parity and consistency; the desire for fairness. At times respondents would express how inconsistency created uncertainty, and with this uncertainty comes anxiety, fear and frustration, noting:

> *"you can never guess whether they'll box you or not. It depends if they like you. Sometimes I've been boxed for hardly nothing, and others have hit staff and not gone in, you know? It's easier for some of us to get boxed than others. It should be fairer Des, you know? It should be fairer."* (PR11)

A final demonstration of patient perceptions of seclusion can be seen in the terminology often used when describing it. Throughout the narratives many of the respondents speak of the seclusion room as 'the box', with the process of being secluded as 'being boxed'. This can be seen throughout the patient findings and noted by different respondents. Of particular interest is that this terminology has its roots in the traditional cultures of the high secure system where both staff and patients commonly referred to seclusion as 'the box'; largely as a result of the traditional box shape of the seclusion rooms. Its use by the respondents here appeared to highlight the punitive aspects of seclusion for patients and perhaps a reflection that in their eyes little has changed from the historical practice of old. It was certainly the patients who had spent the longest time in high secure care that appeared to use this term the most. Examples of this terminology can be seen throughout the chapter.

Over control

A second sub-category of seclusion as an interventional stressor/threat was that of over control. It was noted that patients would not only consider seclusion to be punitive and unfairly implemented, but were also of the opinion that it was deliberately used to maintain control and compliance; to maintain the power

imbalance between staff and patients and proliferate what they saw as the disempowering nature of the high secure system.

Respondents would highlight their perception of this over control in many ways. This included the way in which staff would maintain strict control over the seclusion environment, how they would place restrictions upon movement and access to amenities, how they would use physical restraint as part of the seclusion process, and how at times they would make patients wait for items and attention; deliberately isolating and de-stimulating them.

This issue of controlling the seclusion environment was noted by several of the respondents and was highlighted earlier in the chapter with concerns citing such issues as a lack of fresh air and uncomfortable heat levels. Some respondents also noted frustrations at the limits that would often be imposed on what items they would be allowed to have with them in the seclusion room; often considering this to be overly restrictive, deliberately controlling, and often without valid justification. Some would also perceive staff refusal to often be without good cause:

> *"they could give you a fucking ball, you know?, a tennis ball, just to bounce off the four walls, you know?. But when I talk to her [doctor] about a fucking tennis ball, you know?, that's a sign of mental illness coming back. You know, just give me a tennis ball."* (PR5)

This perceived control of the environment was often associated with the frustrations and anger experienced at the delays in attention given them when in seclusion; often a result of staff making patients wait:

> *"You know, it's quite frustrating really Des, because like, er, you know? you have to wait for every single light [for a cigarette]."* (PR5)

This frustration at having to wait and being denied basic items gave rise to intense feelings of anger with this particular respondent, who likened the frustrations experiences in seclusion to being:

> *"like a lion pacing up and down a fucking cage in captivity, you know?"* (PR5)

This respondent further spoke of frustrations over his treatment in seclusion over Christmas noting:

> *"I asked xxx for a light on Christmas Day, last Christmas Day, at quarter to one, a light, right? Now don't forget Des its Christmas fucking Day mate. Erm, he just started talking down to me in a tone of voice I didn't like. So I said to him 'it's Christmas Day, you know?, haven't you got a fucking heart', and he doesn't care I'm not getting a light [for a cigarette], you know?"* (PR5)

Yet it was not just this respondent who found the experience of seclusion to be so frustrating and potentially arousing and agitating. A further patient recounted a time in which he would be periodically restrained when being taken out of the locked seclusion room to make a telephone call. He noted how some staff would restrain him whilst others would allow him to walk unaided, again highlighting the emotions engendered by inconsistencies in approach and from what he perceived to be a lack of trust:

> *"when I was making a phone call some would feed me out [use restraint to move patient from room], and some would just open the door, let me put my slippers or shoes on and let me walk. But some wanted to put their hands on me. They would escort me to the gate and lock me in and take me back out. And I say 'how come this staff is doing that and that staff is not doing that? What's your game?' And he said, erm, 'it's in your plan to be escorted, to be put in locks'. I said 'No, it's not in my plan to be put in locks to make a phone call' and erm, then they would say something different like. I just went along with it but that was a bit of bitterness like you know? Hurt your feelings for the day like, you know? The more they fed me out [used restraint to move patient from room] was the more I was held back with my plan to get out of seclusion, because I'm not being trusted yet."* (PR2)

These examples provide us with insight into the levels of emotion that can arise through both an over controlling or inconsistent use of seclusion and how they can present as stressors and threats to patients who are subjected to, or threatened with, their use.

This last example also highlights the significant role that physical restraint can play in the perceptions and experiences of seclusion. This was particularly evident in the initiation of a seclusion episode, where some respondents recalled how they would be allowed to walk to seclusion, without restraint, whereas other

would be physically restrained en route. These concerns can be seen in the example below:

> *"I didn't need C&R, I was quite capable of walking down to the seclusion room as I've done many times before. I wasn't shouting or screaming. I didn't physically need restraining; I was psychologically and emotionally restrained."* (PR2)

It can be seen, therefore, that some patients hold strong opinions on the use of seclusion and that its use can give rise to significant concerns arising from perceptions of discriminatory use, issues of over control, abuse, and punishment. Whilst presenting as a stressor and threat in its own right, as noted earlier it also appears to magnify the pressures, antagonisms, annoyances and irritations experienced as part of everyday life in the clinical areas; allowing them to them to take on greater significance and meaning.

Special Observations

Whilst also perceived as an interventional stressor/threat, the patient narratives suggested that special observations do not appear to adversely impact upon them to the same degree as seclusion. They appear to rarely elicit the same behavioural or emotional responses and are often seen as more acceptable and less invasive.

> *"it doesn't bother me Des, to be honest I can do obs all day, as long as they leave me alone [laughs]"* (PR4)

> *"Yeah, obs is better than the box [seclusion]. You can get out and about. Well at least on the ward anyway."* (PR6)

They do not hold the same significance, or raise the same concerns or anxieties for the respondents as seclusion. This is not to say that their use does not have an emotional or cognitive impact upon the patients; the narratives clearly indicated this to be the case at times. One respondent noted

> *"it can get on your nerves sometimes, especially when they keep looking at you on the shitter [toilet]. Can't they even let me shit in peace"* (PR11)

However, whereas the use of seclusion could magnify the relational and institutional stressors perceived by patients, the use of special observations did not appear to hold such influence.

Whilst the use or threat of seclusion appears to reinforce and amplify the tensions and pressures faced in coping with other aspects of life in a high secure hospital, the narratives suggest that patients often appear to be more tolerant and accepting of the use of special observations.

Their impact as a stressor or threat appeared to relate to such factors as the level of observations imposed, the attitudes of staff undertaking them, their perception of the need for such observations, communication about the rationale and parameters for their use, and the interaction with those assigned to support them during the episode (see Diagram 6).

These sub-categories of special observations as an interventional stressor/threat will be explored in the following sections.

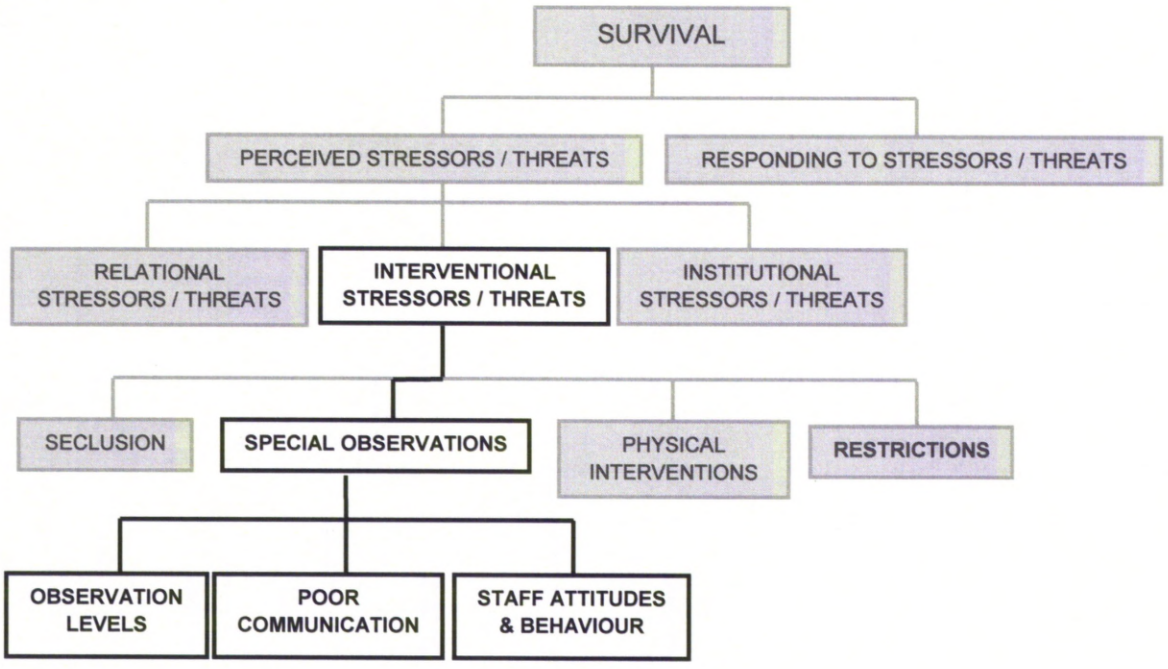


Diagram 6: Sub-categories of special observations as an interventional stressor/threat

Observation Levels

The number of nursing staff assigned to undertake special observations appeared to hold significance for patients, with an increase in numbers assigned often relating to increased stress and anxiety. Respondents would note that when placed on a 1-1 level of observations staff would more often engage with them, appear more supportive and more interested in their problems and concerns. This appeared to stem from the close nature of a 1-1 level of observations where the nurse and patient would often find themselves in dyadic interactions. As the numbers of staff assigned to special observations increased respondents would note that they would be more likely to interact and converse with each other rather than with them. This could lead patients to feel marginalised and unsupported at times, with respondents noting:

> *"it's Ok sometimes, staff will sit and talk with you, you know just be Ok with you; but if there is two of them then you pretty much get ignored [laughs]."* (PR10)

> *"They generally just talk to each other, which is Ok at times, and sometimes I join in, but it depends on whether I like the staff or not."* (PR9)

Of significance in the use of special observations was the patient perception of nursing assistants. Whilst often criticised with respects to the use of seclusion, their role in the use of special observations was not only deemed more positive, but they were often more highly regarded that their qualified colleagues. The patient narratives suggested that nursing assistants were more likely to engage with patients than qualified staff, who would tend to try and undertake the role of observations together with other tasks; at times placing engagement with the patient secondary to other tasks and duties. An example from one of the respondents noted the level of engagement he experienced when a qualified nurse was assigned to undertake his observations:

> *"I was told to sit in the day area while the staff went on the computer in the office. He wasn't watching me, he definitely wasn't helping me."* (PR4)

This level of engagement was not uncommonly experienced by patients, with another respondent noting of a qualified staff:

"he would just sit there looking disinterested like. I'm not that fucking boring am I? [laughs]." (PR10)

The patient narratives were not unanimous, however, in the perceptions of staff being disinterested when undertaking special observations, with some of the respondents expressing a positive experience:

"I don't mind them sometimes. It's better than being in seclusion and it's good to have people to talk to, you know? It can get lonely in seclusion." (PR4)

As noted earlier, it was when the levels were increased above 1-1, however, that the experience of special observations appeared to elicit greater concern. It was at this stage that they often considered the intervention as impacting upon their day to day lives, with some respondents commenting that they no longer considered it part of an individually driven supportive intervention:

"sometimes it can get a bit much like. When there's just you and them they can be Ok with you, yeah? But they upped it to two 'cos I wasn't doing too well and they changed, yeah? They got more strict with me." (PR12)

"they could have taken them off easily, but they always try to cover their arse. 'Wait for the doctor or wait for the ward manager'. It can be like they are just ticking the boxes sometimes. I wasn't going to do anything and they knew it." (PR8)

"I didn't mind too much when there was just xxxx, 'cos she would talk to me, yeah, but when they stuck me on two's [2:1] with a male staff they started talking to themselves. Felt a bit like a gooseberry to be honest Des" (PR3)

This first example highlights the perception that an increase in observation levels corresponded with greater restrictions. However, what was unclear from the narrative was whether the increased restrictions were a result of the increase in staff and a change in attitude as a result of this increase, or whether it was a result of staff perceiving deterioration in the patient's mental state. Irrespective of reason, the patient's perception was that this increase was more restrictive and impacted upon daily activities.

The second example, however, demonstrates the view that at times staff will maintain special observations longer than necessary resulting from an

unwillingness to make decisions; almost fearing the consequences should the decision prove poor. It is clear that in this case the duration of the observations was of concern and that the patient felt it was no longer required. This view that special observations were not justified appeared of some concern to several respondents and led to increased levels of frustration and anxiety at times. Patients who were unable to appreciate the need for the restrictions that the special observations would place upon their day to day functioning were the most vocal in their criticism of the practice.

The final example clearly illustrates how perceptions of staff disengagement resulted from an increase in levels of supporting staff from one to two nurses, although in this example whether this in and of itself was because of the number of nursing staff or the gender mix of staff was unclear.

Poor communication

Poor communication was noted as a sub-category of special observations, with the patient narratives highlighting some concerns about the nature and level of communication with staff. Some respondents noted that on occasion they would not be informed of the reasons why they were placed on special observations, even failing to be told that they were even subject to them at times. This was particularly evident when patients were placed on 1-1 observations, which often requires staff to merely remain in line of sight. This in itself offers opportunity for disengagement by staff and reduces pressure for interaction between staff and patient; at times allowing staff to remain distant to patients. Examples of this lack of communication can be seen in the examples noted below:

> *"to be honest Des, the first time I knew I was on obs was when they told me that they had finished. I didn't know I was even on them."* (PR4)

> *"I went to xxx and asked him why I was on obs, but he just blagged it, you know. I don't think he* knew" *[laughs].* (PR12)

> *"they don't tell you fuck all in here unless they have to. They usually try and fuck you off with an explanation or try and blame someone else. Some of them are bottle-less"* (PR5)

It was not just in communicating the reasons and levels of observations that were of concern to respondents when discussing special observations, however,

with general communication with staff presenting as frustrating and annoying at times. This was particularly evident when patients would attempt to ascertain the parameters of their observations; what would and would not be permitted. Some respondents noted that staff would often be inconsistent both in their approach and in the communication of these parameters:

> *"it can be frustrating at times, you know. Sometimes they make it up as they go along; one staff will tell you one thing and the next says another."* (PR3)

> *"its hard to know whether you are coming or coming [sic] you know. Xxxx's shift usually lets me up to the day area and the garden, but when xxxxx's shift is on I'm usually stuck in the night station with the plebs* (PR3)

> *"you get pissed off sometimes because some will be a bit easier on you and let you do things, yeah?, but others just say no to everything."* (PR8)

> *"it depends who is on Des. If they don't tell me what I can and cant do I'll usually just ask. They can only say no can't they. To be honest they usually do [laughs]"* (PR2)

This inconsistency in staff approach proved a particular stressor for respondents when they felt that choice was limited or negotiation lacking. Some noted that on occasion staff would negotiate the parameters of their observations with them, whilst at other times these would simply be imposed; further fuelling feelings of frustration and disempowerment. Those parameters that were negotiated generally appeared to be less stressful as long as the rationale for their introduction was considered valid; although several of the respondents continued to express their concern over a lack of choice available even when negotiated with staff. Examples of this included:

> *"some of them will talk to you and tell you the score, yeah?, and sometimes they'll give you some options, which is good. But sometimes they just tell you straight [laughs]."* (PR11)

> *"they'll say you can do this or you can do that or the other, but when it comes down to it they still dictate if they want to, you know what I mean? They can talk a good game."* (PR6)

Staff attitudes and behaviour

Staff attitudes and behaviour was established as a further sub-category of special observations and represented an interventional stressor and threat. As previously highlighted, the degree to which patients experienced stressors or threats in their everyday lives appeared to be correlated to their general perceptions of staff attitudes and motivations. This was clearly evident in the respondent's experiences of special observations where the level of concern or criticism was often associated with their perceived relationship with the staff undertaking the observations. On those occasions where patients had good relationships with staff, there was a greater degree of tolerance to the intervention, with comments such as:

> *"I do get on with staff, yeh, Des, so I don't mind being on obs, you know? It gives me someone to talk to instead of the idiots [laughs]."* (PR10)

> *"most of the staff are Ok really; the NA's are better though. They don't make it too difficult, but it can depend on who you get. It can be a bit of a raffle sometimes. If I get someone I don't like I just grin and bear it."* (PR3)

> *"I'm not that arsed who I get Des. I'll always take the females over the males though. I get on better with the females but you know me Des, I can get a bit pissed with some of the males, you know, the wankers [laughs]?* (PR1)

As already highlighted, some respondents experience concern, frustration and heightened anxieties when levels were increased, when staff proximity restricted social interactions and when the restrictions impacted negatively upon their day to day functioning. They noted that when levels increased above 1-1 staff would often appear more restrictive in their approaches to them and generally position themselves closer; potentially impinging upon socialisation and privacy. Respondents commented:

> *"They lasted about two weeks, but they come down from 3-1 to 1-1 after a bit. That helped, you know 'cos it gave me some space. I didn't have to listen to their talking shite all day [laughs]."* (PR7)

> *"some will give you your space, but others get on your nerves when they listen in."* (PR8)

> *"what I don't like Des, is the way some will deliberately sit next to you, just to annoy you like. It doesn't happen all the time, but some of them just try to annoy you, you know?"* (PR5)

It would seem, therefore, that special observations can at times present as stressful for patients, increasing anxiety and eliciting feelings of frustration; even anger and hostility. It appears, however, that in general their use does not appear as concerning or distressing for patients as the use of seclusion.

Recipients would often demonstrate a degree of tolerance and acceptance of the restrictions imposed, until those restrictions start to severely impinge upon specific aspects of their daily lives. This includes severe impositions upon freedom of movement and access to social networks, the assignment of staff whom the patient dislikes, or those occasions when staff may show disinterest or poor communication.

Physical interventions

It was not only seclusion and special observations that presented as interventional stressors to patients, however. The used of physical interventions was identified by many of the respondents as a cause of concern.

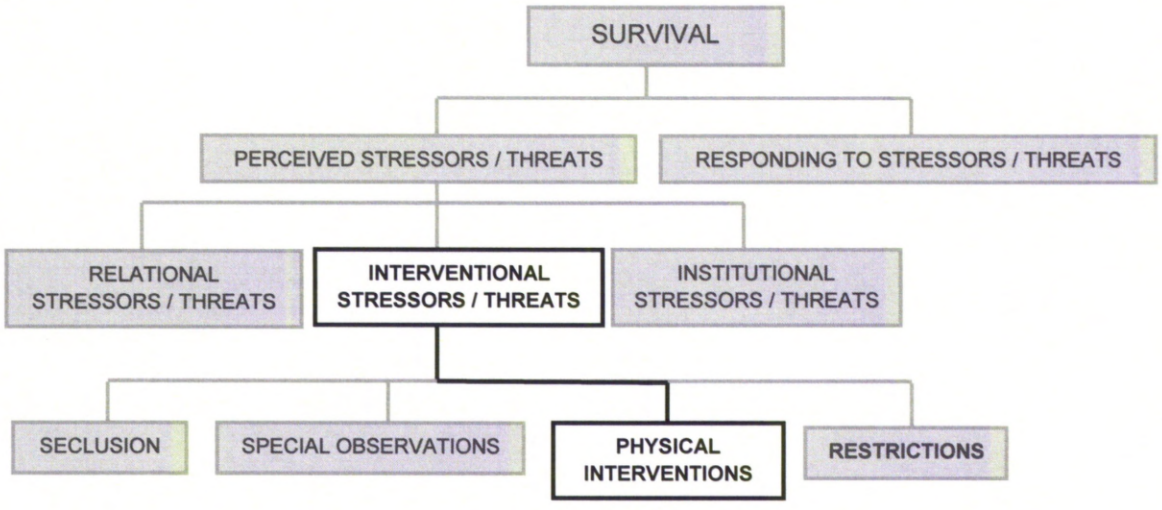


Diagram 7: Physical interventions as an interventional stressor/threat

Evident in the narratives were concerns over the eagerness of staff intervening physically with them and of the feelings its use engendered. Common themes regarding its use included the perception that at times staff would restrain when unwarranted, that there was inconsistency in its use, and that it reinforced to them the power imbalance in their relationships with staff. Respondents would

express fear for their own safety at times and perceive the restraint to be abusive and intimidatory.

Whilst the focus of this study is not the use of physical restraint, it is noted here to be an interventional stressor due to its relationship with seclusion. Often seclusion would follow a conflict situation in which physical restraint had been used, and at times restraint was prescribed as a means of safely moving a seclusion patient from one area to another as part of his care plan when there was a considered risk of continuing danger to others. From the patient narratives it would appear that the use of physical restraint as a result of a conflict situation between patients, or with staff would almost always result in the use of seclusion.

This view from the respondents that physical restraint was unwarranted and over used was often expressed. Patients would speak disparagingly of how restraint was undertaken, the techniques used, and the feelings of humiliation and violation experienced. Comments included:

> *"it's the way they do things, and when they rub their hands all over me and everything you just feel humiliated."* (PR2)
>
> *"And I feel more sort of violated because I'm not like Charles Bronson, if you know what I mean. I'm not strong, I'm pretty weak and not powerful."* (PR4)
>
> *"and they twist you up and say this and that and the thing about it is I've said 'I'm not struggling, why are you twisting me up for, I'm not struggling, why can't I sit down again."* (PR3)
>
> *"they had properly hold of me, you know, I couldn't move. So it was a waste of time you know when I struggled, and I felt like I was being assaulted."* (PR10)

This comment from the respondent above that he felt 'assaulted' was also expressed by other patients, who spoke of feeling violated, powerless and naked; this being metaphorical rather than literal. Patients would also express concern for their own safety and feared physical restraint, not only for its physical restrictions, but also for its symbolic representation, highlighted by one respondent earlier when expressing that:

"I didn't physically need restraining; I was psychologically and emotionally restrained." (PR2)

This quite powerful statement demonstrates the intensity of feeling and concern about the use of physical restraint and how it can be an extremely controlling and disempowering for patients. When used in conjunction with seclusion these emotions would often be intensified even further, with feelings of helplessness and futility not uncommon in the patient narratives. These will be explored further when discussing the responses to perceived stressors and threats.

Restrictions

The final interventional stressor of particular concern to patients was the restrictions placed upon them (see Diagram 8). Whilst restrictions were common place within the clinical area, at times these would present as particularly antagonistic and give rise to feelings of frustration, anger and even hostility and aggression; times often associated with the use of seclusion or special observations. The stressors present within this category relate to those that are imposed as a result of specific staff behaviours or interventions, rather than the restrictions imposed as a general part of everyday life in a high secure hospital; restrictions that form part of the institutional stressors that will be explored later in the chapter.

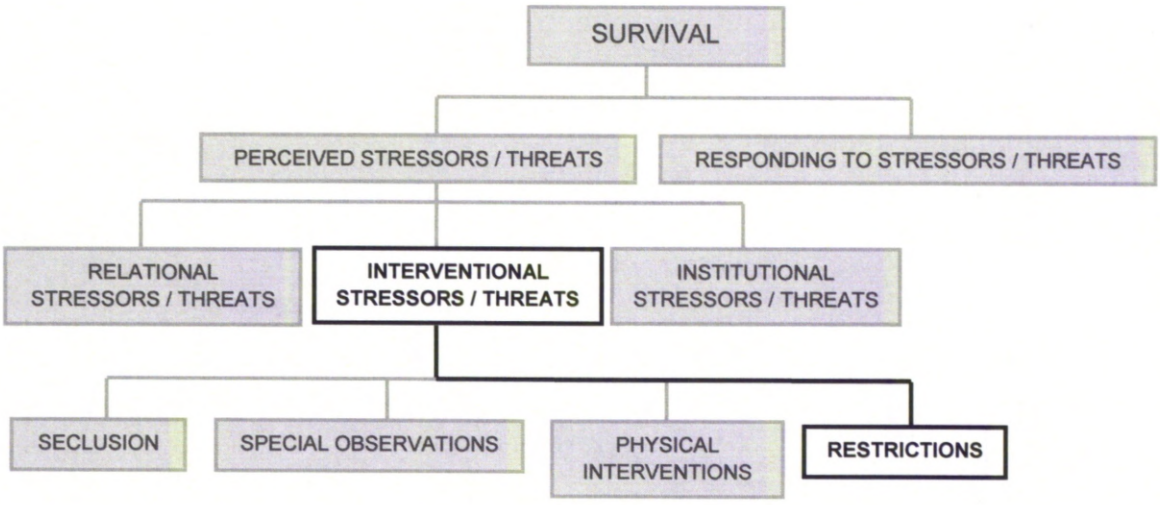


Diagram 8: Restrictions as an interventional stressor/threat

These interventional stressors tended to emerge when everyday functioning was restricted or interrupted without perceived just cause. Restrictions at these times were often perceived by the respondents as threats when they believed staff to be over controlling of the physical environment without reason, when they had to unduly wait for access to basic items and amenities, and when restrictions upon movement within and out with of the ward impacted upon their social and psychological networks and supports.

The narratives indicated that many of these stressors arose not simply because of the restriction imposed upon them, but as much by the way in which it was implemented or instigated. An example of this was seen in the undertaking of personal rub-down and bedroom searches. Whilst the respondents acknowledged and indeed generally accepted the need for these searches, many considered the manner in which they were performed to be deliberately provocative, inconsiderate and antagonistic. One respondent spoke of how a conflict situation arose as a result of staff insisting upon their performing a rub-down search on him, with the situation escalating as a result of the patient believing the staff to be invasive and failing to adhere to procedure regarding dignity and privacy. This resulted in an incident that culminated in restraint and a period of seclusion:

> *`You know I don't mind having them, it's the manner and conduct they are done with that disturbs me and distresses me. But there is no dignity or respect. So I threw a water bottle at them and that's when they jumped on me and took me to seclusion."* (PR4)

Other aspects of control that appear to dominate patient concerns were undue delays in accessing such items as telephone calls and correspondence. When not in seclusion or on special observations patient access to their social support networks raised few undue concerns above and beyond the security restrictions familiar to them. However, when subject to seclusion or special observations access to telephones and correspondence could well be disrupted, with respondents at times considering access to be very much dependent upon the willingness of staff. One respondent spoke of his concerns about delays in receiving his mail whilst in seclusion and the reliance upon staff to ensure this was delivered to him:

> *"It's like your letters. Sometimes my mail comes down in the team leader's envelope and can get lost in the pile. So I had to talk to the staff for them to check; to check the team leader's envelope to make sure they don't get lost. Because I've had mail 3 months after, 3 months after it's been here. It's been here and got lost in the pile."* (PR4)

Another respondent spoke of problems in accessing his peer support network when on special observations as a result of staff inconsistencies

> *"it can grate on you sometimes Des. All you want to do is go the social [off-ward social activity for patients] and they stick obstacles in your way. One shift will let you go and then the next shift say no fuckin' way"* (PR8)

It was evident from the patient narratives, therefore, that patients were largely able to tolerate many of the restrictions present in their everyday lives without recourse to extreme responses. Everyday restrictions were often more readily accepted and on their own rarely lead to conflict situations with staff. The perceptions of these would change, however, when their intensity was increased to the point of interference with daily functioning or when impinging upon specific goal directed behaviours. These would often occur when subject to seclusion or special observations; with the added restrictions imposed as a result of these approaches often fuelling feelings of anger and hostility and subsequently eliciting a response to provide real time emotional or cognitive protection. One respondent noted of special observations

> *"you can generally take them, you know? put up with the crap they dish out by telling you where to sit and what to do. But sometimes it just gets too much; especially if there's a prick [staff] doing it"* (PR11)

3.3.3 Institutional stressors / threats

The final category of stressors and threats experienced were those arising from aspects of the high secure system itself. They are the institutional pressures and threats arising as a result of direct or indirect organisational systems, structures or policies; the ever present annoyances and frustrations patients face whilst detained within a system they consider controlling; such as a high dependency ward within a high secure forensic environment (see Diagram 9).

It is noted, however, that whilst these can present as stressors or threats in their own right, as with the relational and interventional, the intensity with which they are perceived as a stressor or threat is closely associated with the nature of the relationship they have with staff; their perceptions of staff attitudes, values and motivations, and the use of seclusion and special observations.

Diagram 9: Sub-categories of institutional stressors / threats

The institutional stressors and threats perceived by patients have been identified as 'organisational values and ideals', 'challenges to progression', and 'isolation from social and support networks'; each of which will be discussed in the following sections.

Organisational values and ideals

Many patient concerns have already been touched upon when exploring the relational and interventional stressors and threats earlier in the chapter. Other stressors, however, appeared to stem not only from such day to day interactional conflicts with staff, but also from general concerns arising from the treatment received and position held within a system of care in which they are detained.

This detention without limit of time proved of particular concern to many of the respondents who expressed their disdain at how their continued confinement within high secure was dependent upon system determined values, and progress upon staff determined markers. Respondents commenting:

"well, it can make you feel very angry at times, especially when the years are clocking up on you." (PR2)

"sometimes Des you have to jump through fucking hoops, they have got you by the bollocks Des, you know? Jump to their tune or don't jump at all." (PR7)

This perception that the system, through the staff, would determine progress by way of a set of pre-determined markers over which the patients had no control was of concern to many of the respondents. They noted the structure of the care environment to be staff centred, disempowering, and over controlling; expressing concern how the care process offered them limited choice and opportunity to voice opinion or concern.

With respects to pathway and progression through this system, it was significant to note the concerns raised by those detained on civil sections of mental health legislation. These respondents highlighted a system in which they were subject to the same pathway as those detained under criminal sections; believing this to be akin to a criminalisation of the mentally ill and painting them with the same brush as offenders. Examples of this concern included:

"and you know being a section 3, it can be hard going because you're getting treated as if section 41, 37/41... are you with me ?" (PR4)

"I am only a 3, yeah?, but I have to live with nonces and rapists, yeah? And some of them get treated better than me; it's not right." (PR5)

Particular concern was also expressed when these patients actually observed offenders progressing through and out of the system more quickly than themselves, highlighting how:

"you might see someone come in the same time as you for something serious and they make progress and they've gone on their way and there's you here for something minor and you're still here and you can't really see no light at the tunnel." (PR2)

Whilst these concerns appeared of significance for those patients under civil sections, what appeared of concern to other respondents was the emphasis upon

security and its outweighing of any therapeutic values or ideals professed by the organisation:

> *"since the inquiries on the PD wards it got really strict on security. One time you could have picked the phone up and dial any number, mobile phone, any number, any time you wanted to, they never checked it. You can't do that now. At one time you could have a visitor just come to the gate, walk straight in, no I.D., no nothing at all, just come and see you out of the blue. But now you need I.D., you need, erm photographs with your I.D., you need it checked out."* (PR2)

> *"they say I am a patient, then why do they search me every day?, why do they listen to my phone calls?, why do they read my letters?.It's shite Des, I'm telling you, it's fucking shite" [laughs].* (PR10)

> *"why don't they show as much concern over why I feel like crap some days than what I have got in my room that I shouldn't have? It's upside down."* (PR3)

These expressed concerns appeared relational to patient's overall perceptions of how staff interpreted and implemented the security procedures and protocols dictated by the system. Again, this highlights the importance of patient relationships with staff and the perception of threats and stressors. Antagonism in the implementation of rules appeared proportional to the views held by respondents towards staff. Those respondents who held a general disregard for staff would invariably view the imposition and implementation of security measures as more concerning, frustrating, and anger provoking than those patients who had a more positive relationship with them. This is evidenced in the following examples regarding rub-down searching. The first comes from a respondent whom generally appeared more accepting of staff motivations and behaviours:

> *"You know I don't mind having them, because we've all got to be searched now, even the staff have got to be searched."* (PR1)

The second example, however and highlighted earlier in the chapter, comes from a respondent with a particularly hostile relationship with staff. With respects to his being searched, he noted:

> *"That night that fucking xxx wanted to search me and I wouldn't let him search me, right. I said, 'why do you always wind me up when the door is*

fucking locked', right? and he says why do I always be more threatening when the door is locked. Eventually he came in and I just let him search me, just let him search me. But to tell you the truth I felt like fucking smashing the cunt all over the fucking place." (PR5)

Whilst general concerns regarding searching have been discussed in previous sections, as institutional stressors they relate to those criticisms of an organisation which they perceive as supporting and proliferating a power imbalance between staff and patients; a system that fails to regulate staff behaviour, and one they feel discourages patient privacy.

Earlier sections discussed this failure to regulate staff behaviour from a relational perspective, noting that nursing staff were often perceived to stick together; to support one another irrespective of the validity of a patient's case or argument. Here, however, we see examples whereby some patients perceive this lack of regulation to be systemic and not related to the individual relationships between staff, as evidenced by their lack of faith in the hospital complaints procedure:

*"The places I've been like, borstal like, it was more, it was more disciplined than this place. You would put in an application to the governor, and you put your complaint to him, and he'll either solve it or he doesn't solve it. But you know where you stand, and if one of the officers was wrong he would put him right. But at **** it's always the staff that are always right."* (PR2)

"what I was doing Des to get my story heard, I was putting in complaints, right?, because they was writing marks on the computer so I was putting in complaints so people could hear my side of the story, right. And my side of the story is the true side of the story, right? But they always come back 'no evidence', 'no evidence', 'no evidence', 'no evidence', you know? It makes me feel, you know? erm, quite basically that the government is a load of shit. That's how it makes me feel." (PR5)

Challenge to progress

Further institutional stressors and threats of concern to patients were those associated with the challenges and obstacles they perceived in attempting to progress through the high secure system. They considered the process to be heavily biased in favour of the staff, who would often demand unrealistic expectations and offer incentives that were unachievable. Respondents considered

their progress to be largely dependent upon staff, with this lack of control over their own progress giving rise to considerable concern, frustration and anger at times. One respondent spoke of his progress being dependent upon good behaviour and a lack of incidents for a period of a year. He noted:

> *"in my case they are talking about they want a year good behaviour. They want me to do that, they want me to do that; a year. I've had incidents, and erm, I've got to start again. And it keeps on going, keeps on going. It can get you bitter and frustration like because I'm not getting any, not getting any younger like."* (PR2)

This respondent clearly considered this expectation to be unrealistic and was acutely aware of how involvement in conflicts and incidents were held against him and would jeopardise progress. His concerns were further compounded by his perception of other patients progressing more quickly than himself; some with far more serious offending behaviours, highlighting:

> *"if someone can come in for stabbing someone on a beach 99 times for no reason and get transferred to a medium dependency ward, and there's me, probably a bit of an argument and they put it down as being hostile. Then why should he go and I stay when he just come in 3 months before for stabbing someone 99 times? And they're trying to say I can't go because I've got incidents."* (PR2)

This notion of incidents having detrimental effects upon progress was forwarded by many of the respondents who articulated specifically how seclusion would severely hamper their progression through the system. They noted seclusion to be a marker on their pathway and one that could not only halt any progress in the immediacy, but one that could also delay progress off high dependency wards, or even out of high secure. One respondent noted how he was hoping to be seen by a medium secure service for possible transfer out of high secure, but that this was cancelled following a period of seclusion:

> *"Well, I felt bitter because I was expecting a case conference in two weeks time and I knew that's gone down the drain. I was expecting Reaside to come up and hopefully give me a date when I can go back to Birmingham. So I felt really sad. Everything's going against me, everything's gone out of the window. You know?"* (PR1)

This perception of seclusion as a barrier to progress was also commented upon by a respondent when comparing it to solitary confinement in prison and noting how whilst solitary confinement would count towards time served, seclusion would merely delay progress out of the hospital:

> *"you know you've got to get out of that seclusion, right?, to get out of the hospital, right? But in gaol, right?, going down the block it doesn't matter how much you do down the block, or how much bird you do, right? They can only keep you until your fucking day is up."* (PR5)

What the narratives have demonstrated, therefore, is how some patients would often see the high secure system, with its structures and policies, as supporting and condoning practices that at times prevented their progress. This not only involved the use of seclusion as an intervention that served as a marker on progress, but also how incidents in general would be used against patients in their endeavour at moving through the high secure system and often service as incentives to modify behaviour and encourage compliance. Of note, however, is how special observations failed to elicit such a degree of concern over progress, with the patient participants failing to consider such an intervention as a negative marker against their pathway through high secure services.

Isolation from social and support networks

The final group of stressors and threats perceived by respondents arise from the effects of detention and the effects upon their social and support networks. These particularly relate to the isolating restrictions that security procedures are perceived to impose upon their access to specific items, facilities and amenities, and the disempowering nature of the system that they believe limits opportunity to voice opinion; to get oneself heard and have concerns listened to and acted upon. Again, whilst these restrictions appeared to prove of varying significance to respondents, ranging from extreme annoyance to passive acceptance, it was clear that the additional restrictions placed them when in seclusion magnified the stressors perceived in these areas. This was particularly evident when communication was perceived to be poor and negotiated care planning to be lacking, when considering the system as condoning and supporting this lack of communication, and when viewing seclusion as increasing their reliance upon staff to meet needs and plan care:

"I'll tell you how fucking shit this place is Des, right, I have to book my calls in advance so they can listen in, right?, and if my mum wants to visit she has to give three days notice. It's shit mate, honest. Makes you feel like telling them to go fuck themselves sometimes." (PR8)

Another respondent spoke of how visits would take place for him when in seclusion, noting the difficulties in maintaining communication and positive social contacts:

"so I get a visit, yeah?, and I have to stay in the box [seclusion room] *and talk to my family though the hatch. I have to sit on the floor just so I can see them. Its fucking degrading it is."* (PR9)

Again, it is noted that the use of special observations often failed to elicit such a magnified response to restrictions upon social networks and supports except on those occasions where access to off ward social or recreational events would be limited, or when familial visits would be more closely supervised. Several patient respondents commenting that

"its shite when you are on obs because they'll stay with you on the visit" (PR3)

"you know me Des, I can do seclusion or obs standing on my fuckin head Des. But it's when they don't let you go see your mates cos they say you are on obs that really pisses me off. Its only because they are too fuckin lazy to take me" (PR5)

Further respondents spoke of their annual care planning meetings and how seclusion would often limit their attendance and ability to engage in the planning process. These patients spoke of frustrations at being told of the meeting outcomes at a later date and of having limited input into the discussions; providing further evidence from the respondent's perspective of a system that condones and supports staff biased structures and cares little of their opinion.

3.4 Responding to stressors / threats

This brings us to the second core category underpinning the central phenomenon of survival; the response to stressors and threats.

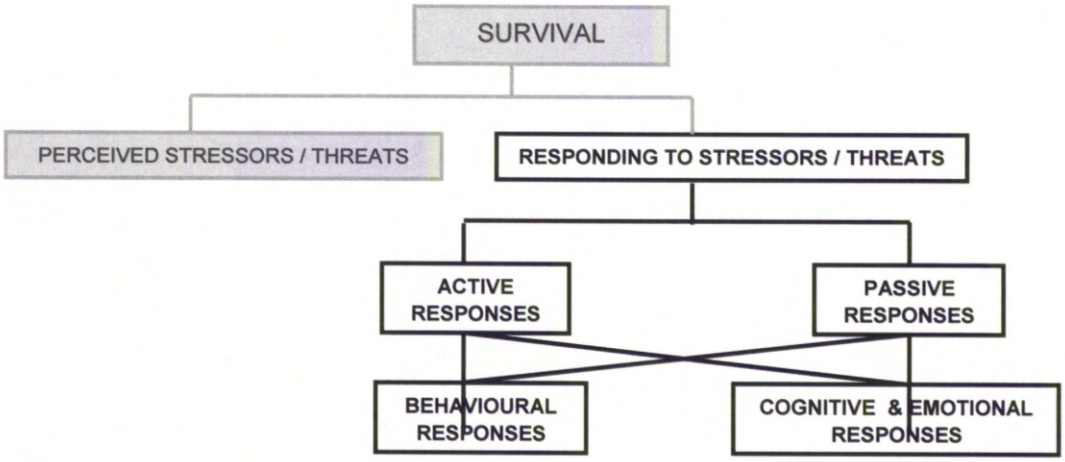


Diagram 10: Sub-categories of responding to stressors / threats

This relates to the emotional, cognitive and behavioural reactions and responses employed by patients in attempting to provide protection from the antagonisms experienced. These responses were noted to be either passive or active, and ranged from the considered and planned, to those more emotionally and instinctively driven (see Diagram 10). They not only attempt to provide protection in the immediacy, but also hold the propensity to either aid or hinder progress depending upon decisions and actions taken.

Actions taken were considered by respondents as having the ability to positively influence their progress through the high secure system, or to negatively impact upon care and treatment, and to subsequently delay, thwart, or even negate progress made to date. The responses were noted to cover both behavioural and cognitive/emotional reactions, with themes categorised as fighting back, emotional motivators, psychological depressors, acceptance and tolerance and playing the game, each of which will be discussed in detail in the following sections.

Active and passive responses

As patients perceive a threat or stressor in their environment they can react either actively or passively. The narratives demonstrated evidence that the decision as to whether to adopt active or passive cognitive, emotional or behavioural responses varied, however, not only between individual patients, but also by the same respondent in different situations. It would appear, therefore, that each patient has the ability to adopt different response styles dependent upon the

situation faced, with reactions dependent upon a number of external factors that include the intensity of perceived threat, the nature of established relationships with staff, general perception of staff attitudes and motivations, and, at times, consideration of consequences and effects upon current functioning and future progress.

3.4.1 Behavioural responses

These responses relate to those behaviours displayed by patients in response to perceived threats and stressors, and represent the actions that are taken, either consciously motivated or instinctively driven, to resolve conflicts and preserve cognitive, social or physical integrity. They can include active responses such as 'fighting back', or more passive responses that demonstrate a more accepting, tolerant or disengaging reaction (see Diagram 11).

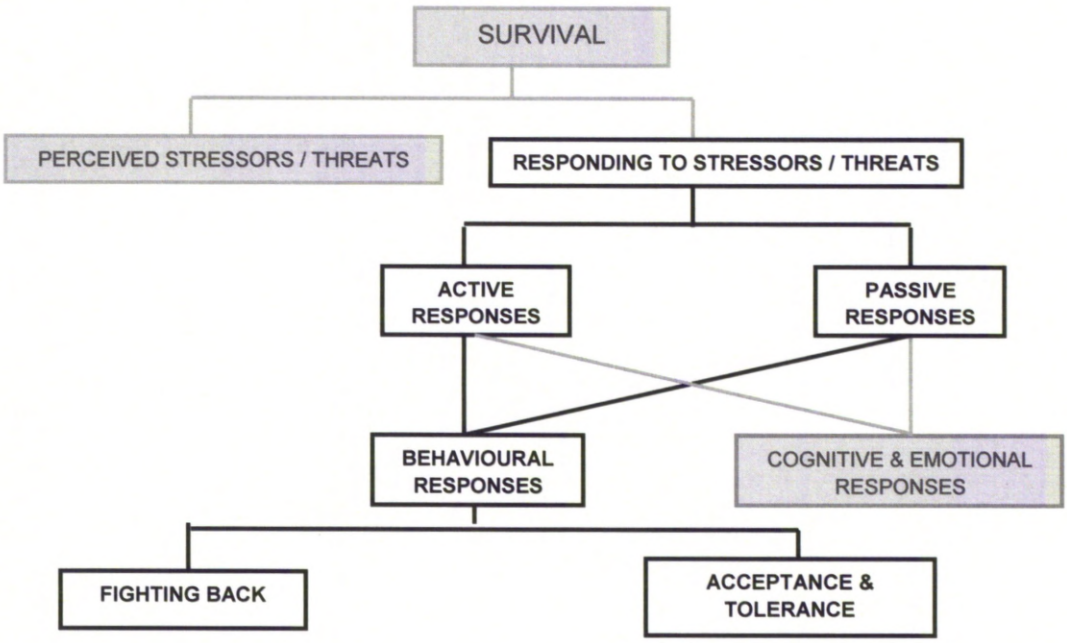


Diagram 11: Sub-categories of behavioural responses to stressors / threats

Fighting Back

This reaction to perceived stressors and threats appeared common throughout the patent narratives. Not just from a physical perspective, however, but also through behaviours that demonstrated a clear, considered action to indicate disquiet through non-compliance or complaints. From a physical perspective respondents would engage in violent and destructive behaviours in what they often

considered to be justified acts against staff or system imposed actions, sanctions or restrictions.

In many of the respondent's recounting of incidents their responses would often be reflective of their perception of relationships with staff, with those respondents with particularly antagonistic relationships with staff appearing more willing and likely to engage in violent behaviour. Those with more positive or neutral relationships appeared more likely to resolve conflicts without recourse to direct violence or destructive acting out. Examples of violent acting out responses included:

> *"Well, I went off my head, didn't I. I told him, 'look if you want to argue with me open the fucking door' and he said 'so are you threatening me'. I said 'I'm not fucking threatening you I am telling you the truth, if you want to argue with me open the door', right? Xxx gets a bit cheeky sometimes. He told me to fuck of didn't he, so I lashed a cup of coffee over him didn't I."* (PR5)

> *"It's, it's hard for me to assault anyone Des. It's hard for me, but he pushes the limit...I just let it go on like. It's hard, I'll normally fight when, erm, someone attacks me, on the spur of the moment I'll fight them. But it the fight happens and it's split up it's hard for me to go back and revenge it you know?, or erm, it's hard, it's hard for me to assault a staff, there's a lot of consequences for assaulting a staff. But that man pushed it too far like."* (PR2)

> *"The two of them were taking the piss like and they fucking knew it. I'm telling you straight, they were asking for it. So they grabbed me on the arms and that's when I lost it. I'm not proud of that Des, yeah?, but they shouldn't have grabbed me; there wasn't a need for it."* (PR1)

One of these respondents with a particularly adversarial relationship with staff spoke of how he also engaged in scatolic behaviour in response to concerns about his treatment and in particular his perceptions of staff motivations and behaviour. With respect to smearing faeces over both his room and himself he noted:

> *"Well, I'm sick of being treated like a cunt on this ward Des. So I thought if you treat me like shit I'll make your fucking ward smell like shit."* (PR5)

This was a clear response to perceived stressors and threats; namely staff's behaviour towards him, and whilst this could perhaps be seen as an extreme response, it was in fact a common behaviour for this particular patient and appeared to provide him with some form of either relief or protection, or at least satisfaction or rationalisation. His continuing narrative offers insight into potential reasons for his actions and the adversarial nature of his relationship with staff:

> *"Des, it's not me, it's them that come the bollocks with me, you know? And they expect me to back down."* (PR5)

Respondents appeared to not only demonstrate these violent, destructive or protesting behaviours when they considered themselves justified, but also at times when they appeared to recognise the potential consequences of their predicament and when they felt they had little else to lose. One respondent spoke of how once engaged in a physical altercation with staff he knew it would result in seclusion and as such resorted with a violent act:

> *"Well, I would have gone in there anyway because he grabbed me. Once he grabbed me that's it. That's part of why I hit him really, because I knew I was going, and I was going on the wrong course."* (PR2)

Another spoke of how he maintained his physical resistance to staff restraint once he knew the incident would result in seclusion. He was able to refrain from escalating this active resistance to actual violence, noting:

> *"I knew when they hold of me legs, when I was laying on the bed struggling, and they said 'you've got a choice here, you know that you can remain as you are when we take the restraint off you and lock the door'. Now I was thinking of kicking them in the face and all sorts (laughs); but I never to my credit."* (PR4)

Other forms of protest behaviours were noted in the patient narratives. These included a deliberate non-compliance with staff requests and demands, presenting as deliberately obstructive during conflict situations and an inclination to making formal complaints. These more passive responses appeared to provide the respondents with an outlet for venting frustration and anger, and for expressing disquiet and disapproval without having to enter into extreme forms of behaviour

that may result in physical confrontation or have more wide ranging adverse effects upon their care and progress:

> *"I used to be a very malicious complainer, and you see it wasn't how many complaints I made. The point was the attention that that complaint or complaints generated with hospital managers. So one of them would look at why I was kicking off, in their words. I don't refuse the searches you know, because I'm looking for attention, or looking for confrontation you know. It's not because I am bored; it's that I am trying to stand up for myself."* (PR8)

This respondent also responded by commencing on food and fluid strikes as a means of non-compliance during seclusion, as a means of taking a stand against staff:

> *"I think it was a matter of pride and self esteem, I couldn't go against my principles."* (PR8)

This influence of internally held values was also noted by several other respondents when articulating their views of seclusion and special observations, although not all respondents with such strongly held values would always choose passive responses as a means of protecting themselves from threats. One respondent spoke of how he considered the use of seclusion to be a means of eliciting change:

> *"You are not going to change me as a person, you just won't do it you won't do it. You know, I live by my morals and I'll die by my morals, right?, and you know you are just not going to change me."* (PR5)

with another expressing the importance of respect as a significant motivator in determining his responses to perceived threats:

> *"speak to people the way they would want to be spoken to themselves. If you come on the bounce to me, I'll come on the bounce back to you. You know?, you speak to me with respect and I'll speak back to you with respect. It's the way it is Des."* (PR1)

As already highlighted, however, there did not appear to be one over-riding motivating force behind respondent's choice of responses, with the same patient's often choosing different strategies to cope with the stressors and threats they experienced; some physical and active, others more passive and less

confrontational. At time patients would respond with defiant, retaliatory or combative behaviours in response to perceived antagonisms, yet on other occasions would actively avoid physical confrontation and adopt positions where they could disengage from the care process, both physically and cognitively.

Acceptance and tolerance

At times respondents would move from a position of 'fighting back' as a means of coping with the stressors or threats experienced, and would at times generate an almost apathetic and resignatory response, demonstrating a degree of compliance and a level of acceptance and tolerance. This avoidance of physical confrontation appeared to stem not only from a fear of consequences in the short term, perhaps through the imposition of such interventions as seclusion or special observations, but also from concern over damaging prospects of progressing through the high secure system. This was evident in the following examples when articulating reasons for refraining from physical confrontation and violence:

> *"Erm, quite basically I want to get out. That's what stopped me doing anything, you know? Believe me or not Des, believe me or not, I'm telling you the truth."* (PR5)

> *"and all these people mounts up for me to say well "fuck it, fuck like do something drastic like. I'm worried about flipping and attacking someone really violently, but there again I think to myself 'where's that going to get me?, that's going to get me nowhere, that's going to get me locked up for even longer time'. So don't do it."* (PR8)

> *"all these things they're just pushing me, pushing me, pushing me, and erm, I've just got to be strong and continue doing what I'm doing and try and keep me head down and behave myself and get out."* (PR9)

One of the most commonly adopted passive responses in dealing with perceived stressors was the desire to self isolate; to actually use seclusion as a means of decreasing stress and anxiety by removing oneself from the source of the threat. Respondents would speak of how seclusion could actually have therapeutic benefits at times, noting:

> *"I just felt more relaxed, I don't have to worry about nothing."* (PR6)

"There are positives in it. So you can just calm yourself down. There are positives in that its best to be behind a locked door when you are like that, because you may just fucking lose it mightn't you?" (PR4)

"I can have the freedom of thoughts and not act upon them. Giving me a bit of time out; it was a bit of respite. That's what I mean by therapeutic, seclusion can be therapeutic as well." (PR2)

Other respondents would also talk of how they become accustomed to the restrictions placed upon them, of the pressures they experience in their everyday lives, and become somewhat apathetic and resigned to these stressors. On such occasions the desire to 'fight back', or even to engage in less confrontational responses appears to diminish, and a degree of compliance and subservience appears to surface. When asked of his feelings about other people taking control over what was happening to him during the initiation of a seclusion episode, one respondent noted:

"Well, I'm used to it Des, I'm used to it." (PR2)

with another expressing the futility of 'fighting back', commenting:

"there is no point, they don't listen to you. If you push it they'll stitch you up and it will only make it worse with me." (PR9)

This notion of almost resignation, of acceptance and conformity, was also evident in the patient narratives around the use of special observations, where there were comments such as

"there's not a lot you can do about it is there Des. If you are on them you are on them. What's the point in arguing, they'll only up them further" (PR12)

"you just let them get on with it to be honest. Just best accepting it and waiting for it to end" (PR4)

"no point Des. No fuckin point. The bastards are just waiting for me to kick off, so I don't give them the pleasure. May as well just suck it up" (PR5)

Yet another also spoke of the futility of seeking support from external agencies at times to aid their plight, noting of solicitors and mental health act commissioners:

> *"Yeah, I would Des, but what can you do about it? The solicitors are no good. (laughs). Erm, you write to the commissioners, they come down and have a chat with the ward manager. The ward manager fills their heads with a load of crap, they go away. They write a lot of letters saying they've had a word with them. Blah blah blah."* (PR10)

Still further passive, non-confrontational responses appeared to arise as a result of patient concern over the potential consequences of more direct actions, or of non-compliance with staff requests or demands. This can be seen in the following examples:

> *"I don't like going in the box* [seclusion]. *That's my consequences. I know I I'll end up in the box. And if I do fight another patient I will go in the box. Even patients have told me that. Staff have had a personal chat with me and saying 'you know what's going to happen', you get the wrong end of the stick and end in the box."* (PR8)

3.4.2 Cognitive and emotional responses

What has been shown so far is how some patients will often adopt and adapt behavioural responses to stressors and threats they perceive in their environment; ranging from active confrontational responses through to the more passive.

However these behavioural responses are intrinsically linked to the cognitive and emotional responses that they first experience when feeling pressured, thwarted or undermined, and the anxieties and emotions experienced as a result of interpersonal conflicts that arise in their interactions with staff. These cognitive and emotional responses have been categorised as 'emotional motivators', 'psychological depressors' and 'playing the game' (see Diagram 12).

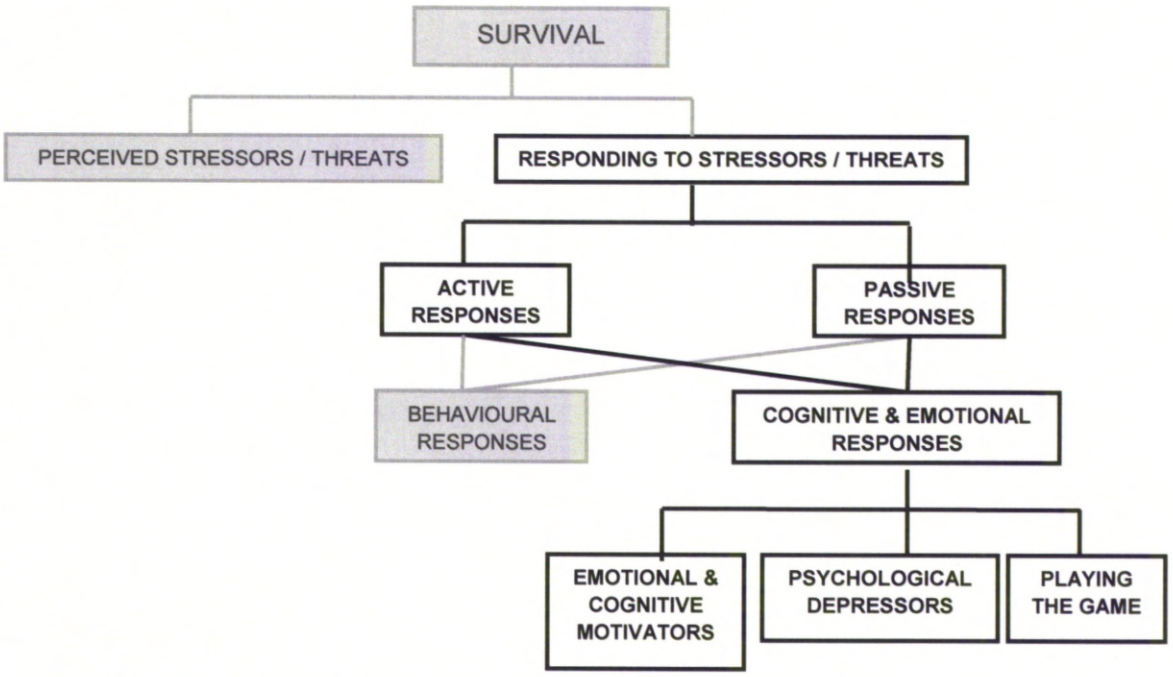


Diagram 12: Sub-categories of cognitive and emotional responses to stressors / threats

Emotional and cognitive motivators

Emotional motivators are those raw emotions experienced by patients when faced with a stressor or threat. They represent the instinctive feelings generated as a result of feeling slighted, disempowered, controlled or abused. They relate to the feelings engendered when engaged in a conflict situation that may result in the use of seclusion or special observations, or indeed those experienced whilst subject to such interventions.

As highlighted earlier in the chapter, many respondents were able to tolerate what they perceive to be everyday stressors. Whilst the narratives clearly indicated that patients feel frustrated, aggrieved, annoyed and victimised in their everyday lives, it would appear that they often consider these as tolerable; accepting their imposition upon their lives as a constant and unavoidable feature of life in high secure care. It is on those occasions where patients perceive challenge, or when engaged in a conflict or highly charged emotional encounters with staff, however; such as those that may result in, or arise as a result of the use of seclusion or special observations, that the significance of these stressors and threats appear to increase to the point of eliciting notable responses. It is when the perception of threat moves from frustration and annoyance to significant anxiety, agitation,

arousal or anger. It is here again that seclusion, yet not special observations, can serve to amplify the negative feelings already present in the respondent's perceptions of their daily lives and detention. At such times patient's awareness and acknowledgement of their position within the high secure system would be heightened and they would often become acutely aware of negative impact that the incident giving rise to seclusion will have on subsequent progress through high secure care.

Respondents spoke of feeling victimised, paranoid, frustrated, angry, hostile, and aroused whilst being secluded or whilst in seclusion, with the duration of the seclusion episode appearing to be specifically associated with several of these emotions. For example, the initiation of seclusion, an intervention often accompanied by physical restraint, searching, removal of personal possessions and isolation from social supports, would often engender feelings of frustration, anger, intimidation, victimisation, and even resignation. Examples of this included:

> *"Well basically I've lost. I'm a victim, yet again."* (PR1)

> *"It just makes you want to scream sometimes, you get all these emotions building up, like, and you feel like blowing, you know?, just saying 'fuck it' and just blowing."* (PR7)

> *"Nothing to gain Des, basically mate. I was the one who was suffering when they secluded me, and they knew I couldn't fight them back but they still restrained me when they took me down* [to seclusion]. *There was no need for it, I was already suffering Des."* (PR9)

> *"What was the point in fighting it? It's a lost cause isn't it? They just get rough if you resist and you end up being the injured party physically as well as mentally" [laughs].* (PR8)

> *"It just pissed me off, yeah?, makes you want to fucking hit out, yeah?. Xxx hit me first but they grabbed me and not him. Xxx wasn't secluded but I was as usual. It's always fucking me, always me."* (PR3)

This last example offers evidence of the respondent feeling victimised and singled out. It is clear that he certainly felt a degree of injustice in the implementation of seclusion episodes. These feelings were also evident in other respondent's narratives and would often be accompanied by other transient

distortions in cognitive functioning that were potentially paranoid in flavour. These feelings and distortions were not only experienced on the implementation of seclusion, but also often noted to increase the longer the duration of the episode:

> *"You see what I've got to be careful of Des, is that I don't fall into sort of when I'm in a world of me own, I feel everybody's against me, you know what I mean?"* (PR4)

> *"Yeah it gives you a bit more time, but after a few weeks Des, it starts getting a bit, it feels like they are brainwashing you. Weird shit starts going through your head mate, you know? erm, weird shit like going through your head."* (PR5)

> *"I suppose I didn't think much about how I was going to get out of seclusion because I knew I would get up within 24 to 48 hours. If it's any longer than that then I start to get worried, [laughs]. That's why I got up, because I start brooding and I start sexually offending in me head and all sorts; it gets kind of hard, you know?"* (PR2)

The data suggests that the duration of seclusion appear significant to patients, who not only experience adverse cognitive and emotional effects, but also appear to specifically relate duration to feelings of punishment; as highlighted earlier by several respondents when commenting:

> "*I think it was in a way like to punish me, like, because they could have moved me back to my room a long time ago and kept me in seclusion there. But they kept me in a strong box more, more than what I spent in my own room. I spent like 4 weeks in seclusion in the strong box then 3 weeks in my ordinary room."* (PR2)

> *"You are locked in there like 24 hrs a day with no fresh air or nothing like that. You're banging your door to get a smoke. Then you become frustrated, then it becomes hard, then it becomes a punishment."* (PR7)

and another, when noting:

> *"They use it as a means of punishment, don't they? But, er, if I could just stay in my own fucking room and get discharged from there; that would do me, that would do me. I'd be away from it all you know?, but they keep you in that fucking room just to punish you like."* (PR5)

It was highlighted in the introduction chapter how seclusion episodes tend to be of a longer duration in high secure psychiatric services, with episodes of weeks, months and even years not uncommon within the high dependency areas of these

clinical settings. As such, the potential negative impact upon functioning, perception and experience of such lengthy episodes cannot be ignored nor underestimated.

Whilst it has been shown how seclusion can have significant adverse impact upon both emotional and cognitive functioning, the data suggests that special observations do not appear to routinely have such negative impact. As highlighted earlier in the chapter the way in which these are implemented can give rise to feelings of frustration and anger, but there was no evidence from the patient narratives that this intervention proved of such concern as to provoke the cognitive distortions or arousing emotional states that was evident in the narratives on seclusion. Special observations appeared to be more of an annoyance than a threat, although of note from some respondents was concern that staff did not treat them with respect; considering inattentiveness and apathy to be common amongst some staff when undertaking observations:

> *"and then some are OK, and they will have a bit of a laugh with you [laughs], but others are just pig ignorant. They'll look at you like you are not there; disrespectful like. They just sit and fill in their forms."* (PR10)

> *"I try and keep distant from them if I can. That's no problem because they mostly ignore you anyway. They only ever talk to you when they're telling you what to do, you know? talking down to you and telling you what to do like."* (PR3)

> *"They have a job to do Des, you know?, but they could look a bit more interested at times, yeah? Try not to make it so fucking obvious they don't give a shit."* (PR3)

Psychological depressors

The earlier section discussed how some respondents would experience some transient cognitive distortions as a response to the initiation and continuation of seclusion episodes. This category of 'psychological depressors' demonstrates how some appear to experience some longer lasting effects upon cognitive functioning as a result of seclusion. These include emotional detachment, psychological restraint, heightened distress and anxiety states, reflection, and prolonged feelings of powerlessness, helplessness and humiliation.

At times they would speak in terms that indicated a detachment from the emotional triggers presented within their environments and particularly around the initiation of restrictive practices such as physical restraint or seclusion. Again, however, this did not appear to be the case with the use of special observations. With seclusion or physical restraint however, there was almost a resignation of defeat with the respondents noting the highly invasive, controlling and disempowering nature of the restrictions being placed upon them. Interestingly they would articulate this without the emotional attachments that the interventions clearly provoked. Examples of this can be seen below in which respondents, who at times spoke passionately and emotively about their plight, would on other occasions appear to acquiesce to their implementation; one noting of the introduction of seclusion. As highlighted earlier, one respondent noted:

> *"Well, I'm used to it Des, I'm used to it."* (PR2)

with another speaking of his time in seclusion commenting how he would:

> *"Just switch off and watch the world go by."* (PR4)

A further respondent also spoke of seclusion without great emotion, noting how on occasion he would utilise time in seclusion as a means of escaping from the pressures and stressors of the ward:

> *"sometimes you just take it on the chin. I've always been a loner, I've always liked me own personal space. It isn't that bad at times; gets you out of the way, you know what I mean [laughs]."* (PR12)

It would seem, therefore, that not only can patient perceptions of seclusion and special observations appear associated with a general perception of relationships with, and motivations and justifications of staff, so too it would appear that perceptions of seclusion in particular can prove transient and dependent upon a number of internally generated patient factors. At times the same respondents would speak quite passionately about a conflict or incident leading to the use of seclusion or talk emotionally about their treatment in seclusion, and yet on other occasions these same patients would appear reflective, compliant, acquiescent and lacking in drive and passion. One respondent was noted earlier in the chapter

as considering himself being 'psychologically restrained', with comments from other patients indicating similar experiences. He also spoke of how this restraint manifested itself in a reluctance to express oneself; to articulate one's own feelings of frustration or anger. He noted:

> *"You see the thing is that pisses me off here, the thing that pisses me off here Des, you know?, you can have a shit day at work, you're kicking the missus or you're kicking the dog or you're kicking the children or whatever. Not physically of course, but you know what I mean?. And, er, you know that's normal. But if you did it on the ward you get booked up with a Class D incident. You can't be normal on this ward, you can't be normal on any ward. If you show any aggression, any anger then you can't handle anger properly; you need anger management". You see what I mean?"* (PR4)

These sentiments of being unable to express oneself was mirrored by several other respondents, who commented that at times they felt powerless and helpless to assert themselves with staff as it would inevitably worsen their situation. As noted earlier, one patient spoke of his concern at the inconsistency in moving him from the seclusion room to the use the telephone, with some staff restraining him and others allowing him to walk freely:

> *"I couldn't push it, I just went along with it; just got on with it like."* (PR2)

Another spoke of the futility and frustration of challenging some staff at times when on special observations, highlighting his belief that staff did not appreciate questioning of their authority:

> *"you tend to just live with it mate, you know?. The more you push the more they blank you off, yeah? They won't get into an argument with you over it, they'll just say 'no', and then write it up the way they want to."* (PR7)

Still other respondents spoke about how seclusion itself could magnify feelings of helplessness, disempowerment and disenfranchise as a result of reflecting upon their lives and their current situation. One patient commented:

> *"As soon as you go in there you start reflecting on your life. It brings you on a downer Des. You have to pull yourself out of that downer, you know?, er, you really do like. You go all through your life, you know?, er, and quite basically my fucking life hasn't been very good, you know? I've had some laughs. I've had some laughs, you know?, er, I've had some good times, but I've mainly had bad times, you know?. And it's not a very nice thing to keep*

going through, erm, when you are in seclusion because the gray walls make you feel fucking depressed. Puts you on a downer." (PR5)

and another noting the distressing nature of such reflection when discussing how he was unable to visit his grandfather before he died:

"Erm, my grandfather passed away and, erm, he told me to come cut the lawn for him before he went, and I didn't go back that day. Then he passed away and most of my time I just dwelled, for some weeks, dwelled on the guiltiness of not going back and cutting the lawn for him. And there is a stone outside the seclusion room window, like a gravestone, and I was looking at it, and I was saying to myself that the most I could do when I get out is go to his grave and tidy it up; put some flowers on it and all that. Cut the lawn there like, and that's the most I can do. And that was playing on my mind for a long time Des. So all that was on my mind, working my mind most hours." (PR2)

It was evident from the examples here that for some respondents seclusion would offer opportunity for contemplation and reflection, and that these would often bring to the fore negative reminders of past deeds, actions and experiences, with the confines of the seclusion room and the duration of the seclusion episode at times exacerbating these reminders.

Playing the game

The final category of patient responses to the threats and stressors experienced is that of 'playing the game'. This group of behaviours relate to those deliberate patient actions aimed at protecting themselves from cognitive, emotional, social and physical dangers and progressing their care and passage through the high secure system. It accounts for the attempts at utilising positive relationships with staff, at exploiting the system, by using external supports and by actively avoiding conflict situations. They represent positive attempts by patients to regain an element of control over their situation and progression; to feel less disempowered and to actively plan for the future by tailoring their immediate responses to threats experienced.

Of specific note, however, was how the same respondents who at times expressed an adversarial relationship with staff, would on occasion also note positive relationships with other staff, and demonstrate an ability to court those relationships to their benefit. This appeared common amongst the respondents,

with all patients recognising some staff with whom they had a positive rapport, and demonstrating the ability to utilise this connection to assist in protection from perceived pressures and dangers or aid longer term progress planning. The patient narratives contained evidence that respondents were able to identify at least some nursing staff with whom they could relate and who would often act in their best interests, although they appeared to remain cognisant of the potential for these staff to side with their peers at times of conflict. Even when subject to seclusion or special observations, however, respondents were able to identify these staff as being therapeutically orientated and willing to assist them in progressing.

What did appear evident in the narratives was the transient nature of long term planning, with the same respondents articulating a desire to progress and 'play the game' also engaging in destructive behaviours that had negative impact upon this. Heightened emotions gave rise to instinctive and impulsive acts that were not always in the patients best long term interests, but offered them a degree of immediate protection from the stressor or threat faced. Examples of engaging in positive attempts at forwarding their care and progressing through the high secure system can be seen in the following examples:

> *"I knew xxx would be round in a minute to get me up, she'll fight my corner. She's been my therapist on a few occasions. I've been secluded before Des, and as soon as xxx comes around she has got me up."* (PR4)

> *"Well, the staff, there are some staff who have a laugh and have a laugh with me. And there are some good staff like who really help me out. Like my primary nurse, he would speak to me, but the main one what would help me out was xxx. They said I was hostile and things like that, and they booked an incident for that, and I had to keep incident free before I could get out like, and with a bit of help from xxx got me out like."* (PR3)

> *"I know I've just got to keep talking with xxx. We have regular sessions and he helps me think things different. I can keep my cool better now and try and let things go over me."* (PR10)

> *"xxx came down and talked to me and said to keep away from yyy. He got me up again and let me go back to my room Des. He was the only one who done that; the others wanted me to stay there [in seclusion]. He's done that before Des."* (PR8)

Other respondents looked not only to nursing staff as a means of aiding their progression, but also to external supports such as family, friends, advocates,

statutory monitoring agencies, and even legal representatives. Not all would prove successful for respondents, however, but they do appear to provide protection from stressors. They appear to offer outlets through which grievances can be aired, authority and control can be challenged, opinion proffered, and opportunity provided to fight their cause without recourse to behaviours that may adversely impact upon care, treatment and progress. Examples of respondents utilising these outlets included:

> *"I didn't really ask until the following day, I asked to see Advocacy and I phoned my solicitor, and he's looking into how this psychologically and emotionally affects me."* (PR4)

> *"I talked to my solicitor about it, and I talked to xxx [advocate] about it and he is going to sort it hopefully."* (PR7)

> *"Well all I can do is phone my mum, speak to her; she'll give me advice. I also speak to my brother, he starts talking about the bible, when Moses crosses the river [laughs], when Moses was crossing the river he did no turning back, and all of a sudden he met dry land and he crossed it, and things like that [laughs]. Seriously, he would be strong and everything, and I used to say to him "it's alright for you to tell me all that bollocks [laughs]."* (PR2)

This strategy of utilising external supports as a means of responding to perceived threats and stressors is seen as an active means of avoiding interpersonal conflict. All respondents were aware of the adverse effects of seclusion upon their progression and were able to acknowledge the need to refrain from conflict if they were to move through the system. It would appear, however, that on occasion this may be easier to articulate in an interview setting than at the time of heightened emotional arousal, when as highlighted earlier, patients may often respond to threats by utilising physical responses such as aggression, violence, or other such destructive or protest behaviours when aroused or agitated. In noting this, however, respondents were able to speak of the benefits of avoiding conflict and how the desire to move through the high secure system proved a motivator at times of stress and threat. When asked why he refrained from assaulting a staff during an argument, one simply replied:

> *"What stopped me? I want to get out, erm, quite basically I want to get out. That's what stopped me doing anything, you know? Believe me or not Des, believe me or not, I'm telling you the truth."* (PR5)

"Well, what I've got to do Des, I've just got to think, you know listen mate you're really not worth it. You're really not fucking worth it mate', I want to get out of this place." (PR5)

Other patients also commented on this need and desire to avoid conflict; noting:

"I've just got to be strong and continue doing what I'm doing and try and keep me head down and behave myself and get out." (PR1)

"You know Charles Bronson wouldn't say that would he? He would have bopped them one. But that's never been my way because I don't believe in violence; it gets you nowhere in here. And look at the state of me, I'm a wreck [laughs]." (PR4)

It can be seen, therefore, that at times some patients will often attempt to avoid direct conflict with staff in recognition of the adverse effects such action often has upon their care, treatment and progress. This motivation to comply with the restrictions placed upon them for the sake of long term progress can be seen as a positive response to perceived antagonisms in their everyday lives. Whilst seclusion is often perceived as one of the most significant of these antagonisms, there are aspects of its use that would appear to assist patient maintaining a non-confrontational approach when responding to threats and stressors; this being the propensity to reflect upon one's own current situation and future. Many of the respondents spoke of how protracted time spent in seclusion would often lead them to reflect upon not only their current predicament, but also about future prospects, hope and ambitions. An example earlier highlighted how one respondent spoke of his desire to place flowers on his grandfather's grave when he was released from high secure care, noting this to be a continuing motivating factor to progress whenever he found himself in seclusion:

"Yeah, I want to do it. I kept on saying that he's gone now so when I do get out I'll tidy his grave up and put flowers there and all that." (PR2)

with other patients commenting how whilst in seclusion they would often reflect upon their plans for the future; noting:

"I kept saying to myself 'it's about time you fucking got out, you've got family out there waiting for you'. I've got someone out there waiting for me, you know? I'm getting married when I get out Des, I'm telling you." (PR5)

"Basically Des, you know, I'm just playing the game to get out of here. You know? I'm just playing the game to get out of here. I've got plans Des, I've got plans." (PR7)

"It just goes round in your head, yeah? You have time to think, you know?, about where you are and the future and that. Just makes you think about getting out, yeah?" (PR9)

There was no evidence from the narratives to suggest that the use of special observations gave rise to any such feelings of contemplation or reflection.

3.5 Summary

This chapter has established how the respondents view the stressors and threats present in their everyday lives; how the restrictions placed upon their movement, access, freedoms and choice impact upon their emotional, cognitive and behavioural functioning. They have illustrated how these antagonisms affect patients in different ways and to different degrees; noting them to be generally tolerable at times, annoyances on other occasions, and aggravators under certain conditions. Of significance is how seclusion presents not only as an interventional stressor within this framework, but also serves as a magnifier with the propensity to amplify the significance and impact of the stressors and threats experienced. The same cannot be said to hold true with the use of special observations, however, which appeared to give rise to less anxiety or concerns on the part of the participants, and generally presented as less of a stressor or threat than the use, or threat of use, of seclusion.

The patients spoke of struggling against staff attitudes and inconsistent staff approaches, of coping with the lack of power and official voice, and of being in a system with an indeterminate release date. They articulated their views of the system as biased against them, of seeing others progress at a quicker rate than themselves and of having to battle against staff collusion, lies and bullying.

Respondents noted a system where their behaviour is always judged, where the consequences for their behaviours can be uncertain and depend as much upon whether a particular staff member likes or dislikes them as it does about the severity or intensity of any untoward acting out behaviours such as expressions of anger, defiance, challenge, questioning hostility or violence

It was demonstrated how the respondents would adopt different behaviours and cognitive approaches to deal with these uncertainties and the feelings and emotions engendered as a result of being detained in this system. They hold progress as a significant issue in their day to day lives and note that this is often determined in terms of clinical markers such as ward placement, individual response to therapy, or referral to other health care providers of lesser security. These clinical markers hold significance for patients in their perception of where they are in their journey through the high secure system. They noted how behavioural expectations placed upon them can serve as determinants of how far along their journey they currently are and what milestones they still have to achieve in order to progress out of the system.

The patient narratives to one degree or another focused upon the importance of the temporal aspects of life in high secure care. They noted how the impact of the indeterminate nature of their detention can influence and drive behaviours in either positive or negative directions; either aiding or hindering progress. For some the impact serves as a motivator, whilst for others it is a barrier that can frustrate, anger and ultimately lead to further self defeating behaviours such as violence or destructive acting out. Others, however, appear able at times to temper their feelings and behaviour towards more productive goal orientated behaviours, refrain from using violence, and 'play the game' in order to progress through the system; although it is also noted that such productive behaviours can often appear transient.

These different behavioural and cognitive responses are not mutually exclusive, however, with respondents frequently moving between the self defeating through to the more considered and positive. The data suggests that patients are often acutely aware of how movement between these barriers or aids to progress can adversely or positively affect length of time in the system. They are also acutely aware of how an adverse incident of hostility, aggression or violence can undo months or even years of working towards progress.

Patients spoke of having to survive in a system in which events are marked by months or even years. This can lead to difficulty in reconciling day to day survival with long term plans; with patients often living for the 'here and now' when

struggling to survive in what they perceive as an oppressive system. These survival behaviours serve a protective function, and whilst many short term coping behaviours, such as pre-emptive or retaliatory violence, questioning, complaining, challenging or self isolation may prove self-defeating with respects to progress, they are at times instinctively driven and provide immediate psychological or emotional protection. At times it can prove difficult to maintain sight of long term goals when faced with day to day pressures of coping with life in the high secure system.

The data suggests that when patients are able to think about their long term goals they appear to try and move away from the need to provide immediate self protection to a more considered outlook. This more productive approach can be characterised by self determination, use of external supports and utilising their interactions with staff whom they have a positive relationship. Patients at this stage try to stop 'fighting the system' and become active agents in trying to positively influencing their own future. This more reflective, considered outlook allows patients to move away from violence and conflict in their interactions with staff. Unfortunately this move from behaviours that can hinder to those that can aid progress rarely occurs in a linear or even temporal manner, with patients often fluctuating between the two for significant periods of time; some for years, some indefinitely.

There are many comparisons that can be made between the experiences of the patient participants in this study and the observations made by Goffman (1961) in his study of 'total institutions'. There were a number of specific elements of the contemporary culture and delivery of care at the research site to demonstrate continuing similarities with the characteristics of 'total institutions'. This specifically included a process akin to the mortification processes noted by Goffman, whereby the patient perceived he is subject to a process of depersonalisation, a stripping of social roles and isolation from support networks, and a formalised privilege system whose aim was to regulate behaviour and promote change. Through mortification the patient becomes one of a collective at the expense of individual need, and through a privilege system, known and recognised by both staff and patient groups, the ground rules are established by which patients' behaviours are judged and acted upon by way of rewards or sanctions.

Whilst many aspects of life in high secure care were reminiscent of the observations made by Goffman, the use of seclusion was noted to be of specific significance to the patient participants in this study and was seen to incorporate many of the elements of the mortification process and privilege system; particularly those of depersonalisation, poor staff attitudes, abuse and punishment. It was through the use of seclusion that the patients appeared to experience the highest degree of depersonalisation, feelings of powerlessness and helplessness, anxiety and frustration.

Noteworthy, however, is how the use of special observations, whilst featuring many of the same elements of the mortification process failed to elicit the same degree of concern or distress to the patients. There was a greater degree of tolerance to the use of this intervention, even when social networks were disrupted and freedom of movement curtailed. It is perhaps in this acceptance of the use of special observations, and the attitudes and opinions expressed by the patient respondents that was one of the most significant findings from the study. An intervention that the literature holds to be invasive, controlling, demeaning and inhumane, was largely seen by the patient respondents in this study to be both tolerable and acceptable. The negative emotions attached to the use of special observations in the literature were not experienced or described by the respondents in this study. Whilst there were elements of annoyance and antagonism evident in some of the narratives, there was almost a resignation with some respondents that their use was the better option than confinement in a room (seclusion) and that the imposition of special observations did not hold for them the same negative consequences upon daily living or clinical progress as seclusion. This perception of special observations as having a less coercive, punitive, or oppressive impact upon the patients within a high secure setting has added to the sparse existing literature on the use of this intervention for the planned management of violence and aggression, has highlighted implications for future practice, and opportunities for therapeutic engagement not previously realised.

One final note with respect to the patient findings was the observation that many of the respondents at interview would make use of humour. This can be seen in many of the examples provided in the chapter. Despite often talking of intensely personal feelings of being abused, victimised and punished, the respondents would

at times make use of humour within the interview setting; often laughing and speaking in a light hearted and jovial manner. The use of humour appeared to be more of a means of protecting themselves from the emotional anxieties that the recalling of some events may have generated. Humour appeared to be used as a defence against the emotional impact of the experiences.

Part Two: The staff experience

3.6 Introduction to the findings

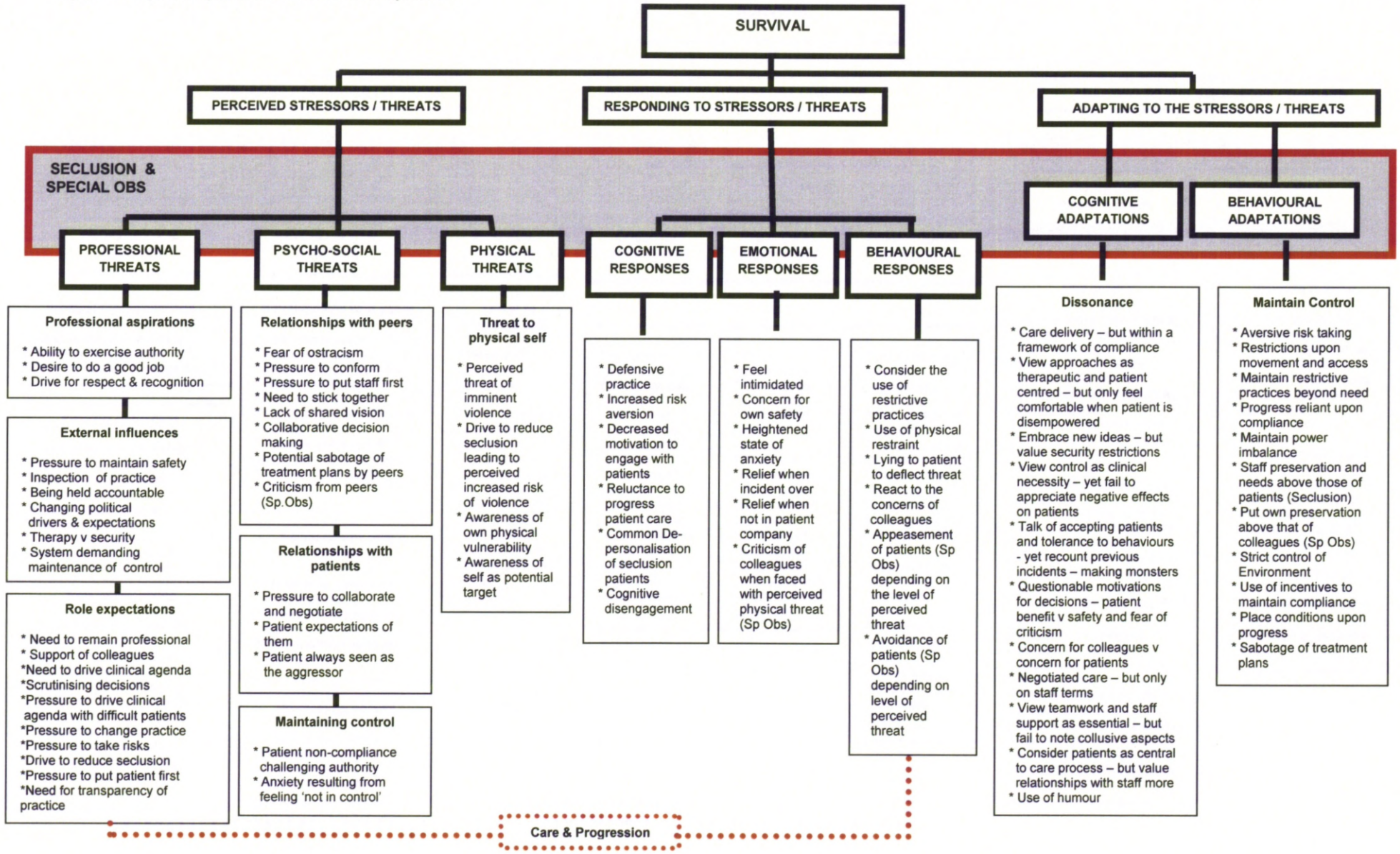
This part of the chapter discusses the findings from the data collected on the staff experience of seclusion and special observations. As with the patient findings earlier in the chapter, it forwards an interpretive theoretical framework that reflects the experiences and meanings attributed to these interventions by the staff respondents working on high dependency wards within a high secure setting. In doing so it highlights the challenges faced by these nurses in working within what they perceive to be a hostile and threatening environment, and provides insights into the pressures they encounter in their everyday contact and engagement with patients.

The structure follows that of the patient findings, in that it reflects the development of the theory from the initial coding and categorisations through examples from the data. This reveals how the explanatory and interpretive framework was established, and is supported by discussion and exploration of each category and sub-category to illustrate their relatedness and relevance to the framework. This demonstrates the challenges, conflicts, stressors and pressures the respondents perceive in the management of patients; particularly those in seclusion or on special observations.

3.7 The theoretical framework

As with the patient experiences, survival was noted to be the central phenomenon; the defining concept that reflects how staff perceive, instinctively and intuitively respond, and subsequently adapt to pressures and anxieties in what they perceive as a hostile and dangerous workplace. The framework illustrates how general concerns are magnified in the face of having to provide care, treatment and management to patients they perceive as dangerous, unpredictable, challenging and difficult, and how at such times these are perceived as either a threat to physical safety, professional integrity, or psychological or social functioning. A graphical representation of the framework can be seen in Figure 4 below.

Figure 4: Graphical representation of the staff experience



Integral to the framework is how nursing staff respond and then ultimately adapt to these stressors and threats, and how the existence of such hazards to wellbeing, functioning and status are managed, reconciled and integrated into their working lives. It is through the examination of the identification, response and adaptation to pressures and conflicts, and the relationship between them, that the use of seclusion or special observations can be understood.

The use of seclusion and special observations, and the interactions that give rise to their use, were significant events in the working lives of the staff respondents and were often perceived as threats to functioning, safety and wellbeing. It is how these nurses respond and adapt to the stressors arising from these interactions that provide insight into the experiences of working with patients in seclusion or on special observations within a high secure setting; how they survive what they perceive to be an ever present challenge and potential threat to their survival.

This theory of survival is underpinned by three distinct core categories; labelled as 'perceived stressors and threats', 'responding to stressors and threats', and 'adapting to the stressors and threats'. Each core category is itself composed of several categories and sub-categories that were derived from the raw data and subsequently bound together to form broader themes, compared to further data, and ultimately formed into separate sub-categories and categories as relationships between themes, ideas and concepts emerged.

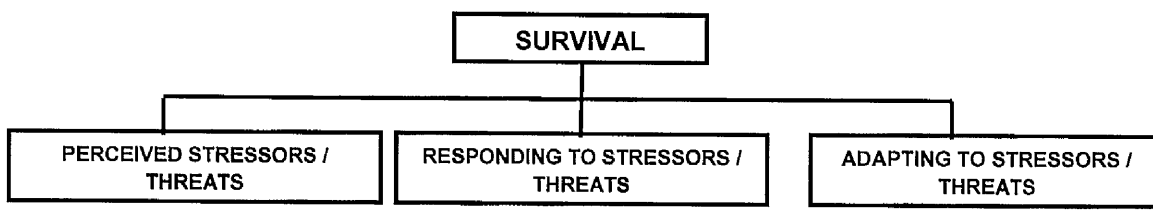


Diagram 13: Core categories of staff experiences

The following sections will explore each of these core categories and their respective lower level categories and sub-categories; exploration that illustrates how the theory of survival was developed from the grounded data. It highlights how theory development is dependent upon the inter-relatedness of categories, sub-

categories and the individual constituent elements of these. As such, the discussion of each element contributing to the development and refinement of the theory shows evidence of over-lap at times, with the same concepts and constructs relating to several key themes.

3.8 Perceived stressors / threats

The first core category is that of perceived stressors and threats. This category illustrates how the respondents experience pressures when exercising their duties; conflicts and stressors that impact upon their physical, emotional, cognitive or behavioural functioning. The staff narratives presented a picture of detailed concerns arising in specific situations; situations directly relating to the care, treatment and management of whose whom they perceive as particularly challenging or difficult.

These threats and stressors fell into three distinct categories; namely threats to the professional self, threats to psycho-social functioning, and threats to physical health and wellbeing (see Diagram 14). The following sections will explore each of these categories and sub-categories in turn, using examples from the narratives to support the analysis and interpretation of the data in the development of the theoretical framework and the concept of survival.

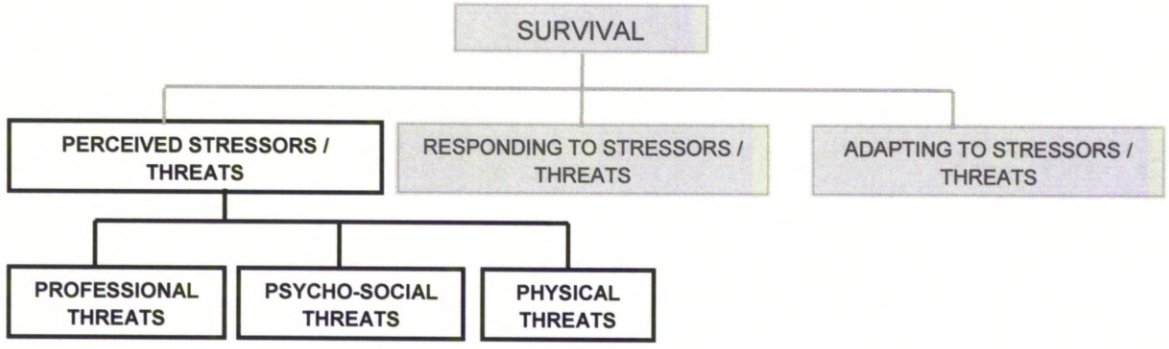


Diagram 14: Sub-categories of perceived stressors / threats

3.8.1 Stressors / Threats to professional self

Stressors and threats to the professional self specifically relates to the respondents concerns about their professional role and how they view the potential impact upon their professional life arising from the challenges and conflicts experienced during the undertaking of their duties. These concerns were more

pronounced when discussing clinical decisions that they felt may be subject to scrutiny by management or criticism by colleagues, and tended to focus upon professional reputation, career development and organisational sanctions. It was on those occasions where they perceived their professional integrity to be threatened that anxiety levels were heightened and concerns became more prominent. It was clear from the staff narratives that the potential impact of the challenges threatened how they perceived their professional status and ability to maintain their professionalism. This category of 'professional threats' itself comprised distinct components, or sub-categories that specifically related to professional aspirations, external influences and role expectations (see Diagram 15). These are discussed in the following sections.

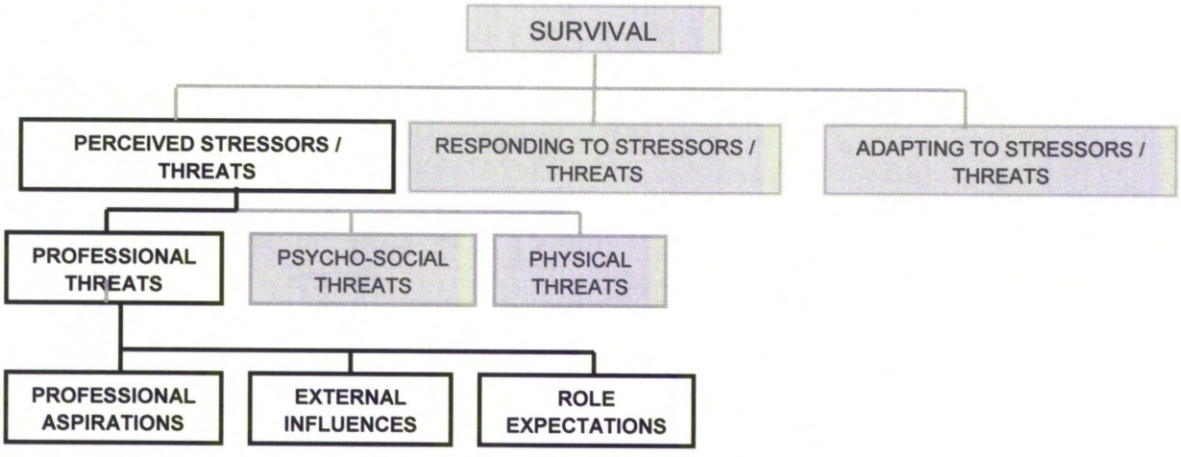


Diagram 15: Sub-categories of professional threats

Professional aspirations

Professional aspirations consisted of three main elements; the exercising of authority, the drive for respect and recognition, and the desire to do a good job. The category represented the respondent's recognition of the professional nature of their job, of the need to maintain a degree of professionalism in their outward projection of attitudes and values, and of the importance to have this professionalism, this status, externally validated.

The perceived importance of exercising authority was more often articulated by qualified staff; particularly those who had responsibility for a team of nurses, and appeared to reflect the need for their employed position held within the organisation to be recognised by both colleagues and patients alike. They spoke of

their position making them organisationally strong, and of having, and subsequently using, the ability to direct the trajectory of care with patients in seclusion or on special observations. With this power, however, comes the potential for criticism by colleagues and the recognition of the need to remain mindful of the concerns of other staff. This was emphasised by one respondent who noted:

> *"I can instruct people to do it, and as long as it is a reasonable request, organisationally I am very strong. But it's about listening as well, listening to all these individual needs, all these individual feelings staff have about individual patients".* (SR1)

This respondent demonstrated a strong desire to have his professional position validated by both the organisation and colleagues, believing his recognition of their feelings as an important factor in their perceiving him in a positive light. This balancing needs and concerns of both patients and individual staff appeared anxiety provoking, with the respondent demonstrating a difficulty in the directing of colleagues and appearing concerned for the potential ramifications of this upon their perceptions of him. He noted:

> *"It doesn't come easy. It's not easy sometimes to tell people to do things they don't want to do. You can take a lot of flak if things go wrong. Makes you the villain sometimes, you know?"* (SR1)

Although the respondent considered his professional position within the organisation to be one of strength he still expressed concern over using this organisational power without the support and approval of his colleagues for fear of criticism. This expressed concern highlighted potential anxieties associated with the leadership requirements of his role and in having to make unpopular decisions.

Other respondents commenting upon the professional power that the organisation provided them, recognised that at times there was a need to direct members of staff to get patients out of seclusion if they demonstrated reluctance to do so of their own volition, even if this directing was not always encouraging, supportive or motivational:

"sometimes I do go down and have to say 'right come on' and sometimes they do need a bit of a shake up. 'Come on bloody hell I'm giving you the tools to do the job and you are not doing it. 'Get xxx up'." (SR4)

The data suggests that this directing of staff can provoke feelings of both anxiety and guilt a times. These feelings of anxiety appeared to arise from concerns over potential criticism from colleagues and were reflected in respondents expressing the need to keep working with staff, to 'win their hearts and minds', and to keep them on board with proposed plans of care. This was often despite having a strong professional power base, with qualified respondents in particular appearing apprehensive about how they were perceived by their colleagues, and articulating concern about how criticism may impact upon their professional standing within their immediate peer group.

Whilst feelings of anxiety were rooted in the fear of derision from colleagues, the feelings of guilt appeared to stem more from concerns that decisions and directions would impact negatively upon the health and safety of colleagues. One respondent noted:

"and then I think to myself 'what if I do this and someone gets battered, somebody gets really hurt, you know, as a person I would feel guilty. If I had driven somebody to do something risky and it had gone wrong I would feel guilt." (SR4)

With another commenting how concerns over the potential impact of his decisions adversely affected his sleep pattern

"I don't know how I cope with it, I don't know. Erm, not very well, sometimes [laughs]. Erm, not getting to sleep at night, sometimes. I wouldn't say you know 'god, I'm worried about this all the time', but it does, when I am making a decision, when I am thinking about something, it is there at the back of my mind, I do think about it. I do". (SR2)

More generally expressed anxieties, however, appeared to relate closely to the aspiration to do a good job, with respondents commonly articulating values synonymous with those of a caring health care worker. These included expressions of caring 'passionately' about the patients in their care, of being 'patient centred' and of feeling frustrated and dismayed when patients did not "progress" as they

had hoped. This was often demonstrated when speaking of seclusion, with comments such as:

> *"it just doesn't sit easy with me to have a 28yr old fit healthy young man locked up 24hrs a day, you know, in a room."* (SR4)

> *"but it was a frustrating one because we were all disappointed that it ended up that way* [seclusion]. *The whole team was fed up that we had ended up that way because we really thought that we had actually made some progress with this lad and we could have talked him round."* (SR3)

and in speaking of special observations when commenting

> *"we had xxxxxx on obs for months. It was hard motivating yourself every day to try and get into his head, to try and get him well. It just took too long. It was frustrating"* (SR6)

> *"sometimes its like groundhog day Des [laughs], you sit with the patient day in and day out and rehash the same old topics. Sometimes you don't see any light at the end of the tunnel"* (SR2)

These concepts of patient care and progress ran consistently through many of the respondent narratives. The data suggested a relationship not only to expressed values of caring, therapeutic engagement, or to a general theme of clinical improvement, but also to a perception that patients in seclusion had to 'progress' in order to have their seclusion terminated; that there was a process to work through. These concepts are discussed further when considering threats associated with role expectations and their link to staff responses.

All grades of respondents expressed the desire to do a good job, with the data suggesting they experienced a sense of pride and satisfaction in how they undertook their role. They considered their approach to the role to be professional and in the patient's best interests, noting:

> *"I've learnt how to be a professional, I've learnt how to be a nurse, erm, I've learnt how to interact and work properly with patients."* (SR6)

This desire to do a good job appeared to come as much from internal beliefs and value systems than from any professional or career benefits that could be gained.

Respondents articulated what appeared to be genuine expressions of concern for patient welfare and progression, and saw their role in this to be benevolent and positive. These internally generated motivations were demonstrated by one member of staff when talking about the successful termination of one patient's seclusion episode:

> *"there was times when you just wanted to hug the lad, and you know you felt, I wouldn't say close to tears, but quite emotional about it because this lad who everyone had built up and presented as the incredible hulk, a killer locked in a room, suddenly became this really quite pleasant chap and I was buzzing."* (SR9)

And by others when talking of the successful use of special observations

> *"its hard to believe he's walking round the grounds now. He's done so well. It was the obs that enabled us to work with him. We weren't getting anywhere when he was locked up* (SR8)

> *"special obs give us the opportunity to change things. You know?, to break down that barrier, to get into him"* (SR11)

The satisfaction of dealing with particularly challenging patients was evident in the accounts of many staff respondents. They spoke of feeling frustrated when patients relapsed and of feeling euphoric when patients progressed out of seclusion or off special observations. There was a strong theme running through the staff narratives that seeing patients move through the high secure system was important to them in the execution of their duties.

Closely associated with this desire to see patients move through the high secure system, and to do a good job, was the drive for respect and recognition; not only from peers and colleagues, but also from patients and from the organisation itself. Whilst respondents would express frustration when patients relapsed, they would also talk about the pride felt when challenging patients had their seclusion episodes or special observations terminated, and how this reflected positively upon the ward, the clinical team, and themselves. Two respondents in talking of their role in the termination of a seclusion episode for one particularly challenging who had been in seclusion for some considerable time; commented:

"there was a number of occasions where we were almost proud of the fact that we were actually going to do this. Almost a pride thing where you could say others have failed and we'd actually achieved it." (SR6)

"and I think maybe part of it as well was that I felt proud to belong to this nursing group that had sort of done something for him, and I felt like I had achieved something. I felt like I had done my job." (SR9)

With further comments about special observations noting

"it was a good feeling to finally get xxxxxx off his obs. We thought it was going to go on forever [laughs]. Give the lad his due, he is coping without the support" (SR6)

"what you have to remember Des is that we don't like sticking people on obs. We don't do it for the fun of it, we do it to try and help patients. It feels good when you see them getting better and having them reduced" (SR10)

Whilst many of the respondents appeared concerned about their own professional standing and their role in providing patient centred care, concerns were also expressed that at times professionalism was difficult to maintain in the face of patient aggression and hostility; particularly the ability to contain emotions. An example offered by one respondent explains how on occasion staff may not always speak to patients in what they themselves perceive to be a therapeutic manner; particularly at times when that staff may be experiencing increased levels of anxiety or arousal:

"Staff may be angry with xxx as well and probably talk to him, maybe not like he was shit, but certainly not in the most beneficial or therapeutic way." (SR9)

This conflict between the need to remain professional and the allowing of one's emotions to rise to the surface and potentially engage with patients in a less than therapeutic manner would appear to be the cause of some anxiety. Of interest, however, was that respondents tended to observe such behaviour in colleagues rather than themselves. These respondents recognised the potential difficulties in displaying professionalism at times, of promoting therapeutic values and maintaining their professional aspirations, particularly in the face of extreme threat and pressure.

External influences

The second sub-category of professional threats was concern over external influences. There was common awareness of increasing external pressure to reduce the use of seclusion and to have aspects of care provision scrutinised by external bodies. Respondents spoke of remaining mindful of these external pressures when planning programmes of care and when intervening with particularly challenging and difficult patients. Specific elements of these external pressures were noted as the pressure to maintain safety, the inspection and scrutiny of practice, being held accountable, changing political drivers and expectations, the balance between therapy and security, and the system demanding the maintenance of control.

This pressure to maintain safety came not only from peers and colleagues, but also from the organisation and from external motivators to maintain professional integrity. One respondent spoke of how he felt at times the use of special observations may be used for several reasons; not all clinically driven:

> *"I think we do use them to protect them as individuals, but also to protect the organisation, and occasionally us from a PIN* [registration] *number perspective. I wouldn't want to guess as a percentage, but I think there are times, yeah, where we do that."* (SR9)

The data suggests that at times nursing staff can perceive themselves to be faced with several competing demands; with pressures from each demand placing different expectations upon behaviour. It suggests that at times this respondent would adopt a defensive approach to practice that may be driven from personal or organisational concerns rather than by patient clinical need.

Some respondents spoke of occasions when they felt their actions would be judged, and that this in and by itself at times influenced their decisions when considering the use or management of seclusion and special observations. They recognised this increased inspection and scrutiny of practice, noting:

> *"I think we are under pressure, but I can't ever foresee that pressure going, it's how it is now and how you view it"* (SR4)

Some members of staff also articulated their concerns about being blamed and held accountable for untoward incidents; this being particularly evident with qualified respondents who have professional accountabilities above and beyond those of nursing assistants. These concerns were based not only upon potential sanctions that the organisation may impose, but also those that may affect their professional integrity and standing. One respondent spoke of concerns over accountability when talking of undertaking special observations; noting:

> *"you are always aware that if something goes wrong then you are out on a limb; I'm always concerned that if something goes wrong I'll be left carrying the can"* (SR8)

Intrinsically linked to this perception that staff would be held responsible for untoward incidents and individual practice decisions was the recognition that political drivers and expectations were constantly changing in response to such influences as national guidance and Department of Health policy and directions. Some respondents' spoke of how the focus and priorities of the organisation would at times appear to be on attending to external reporting and recording requirements rather than attending to patient care; one noting:

> *"I think we have become this "tick-box" kind of organisation. There is all different tick boxes that we have got to meet, and I think that can have a negative effect because you are striving to tick these boxes without looking at the individuals needs."* (SR5)

Other respondents recognised the shift in focus between security and therapy in recent years and noted this concept of security versus therapy to be of particular importance in their day to day working lives:

> *"there is always the debate about security versus therapy, and whether we are too security minded. I think we have probably got it about right at the moment. I mean you can argue for both sides really, that we go too far with security and that it's over the top, but it is a much safer place. I think we are getting the balance just about right now."* (SR4)

This perception that the current balance was appropriate was shared by several of the respondents, although not all. Some expressed the opinion that the balance had swung too far towards security at the expense of therapy. This was noted by several respondents when discussing the induction of new staff into high secure

services and the focus upon security present within the new starter's induction programme:

> *"we have got people like nursing assistants who have never worked in a high secure hospital who get taught, absolutely rammed down their throat, how dangerous it is and the type of people that we are dealing with and I think they are a bit confused that they are working in a prison or in a hospital."* (SR2)

> *"I think it's a bit mixed up in some people's minds whether we are a hospital or a prison sometimes."* (SR1)

> *"I do feel this as a bit of a negative, this security side. I always feel there is a problem with the security side."* (SR3)

What was evident in the staff narratives was the potential for this issue of security versus therapy to cause concern for staff in their every day undertaking of managing patients in seclusion or on special observations. The data suggested that individual perceptions on the balance between security and therapy varied amongst respondents. Some respondents perceived an over emphasis upon security, considering their clinical practice to be restricted at times; complaining that some staff would use security restrictions as an opportunity for not engaging with patients and for not progressing plans as quickly as they themselves would like.

Similarly, the staff narratives highlighted that other respondents did not consider the balance to restrict their practice, but expressed concern and increased anxiety when perceiving the importance of security to be placed secondary to therapeutic pressures and drivers. The data suggested this to be closely related to the rigid application of rules and security procedures when managing seclusion or special observations. This avoidance of 'grey' areas appeared to motivate a number of respondents in the undertaking of their seclusion or special observation duties, with one respondent commenting that:

> *"If you don't divert from the rules, you know where you stand"* (SR8)

Respondents often failed to articulate the potential differences between strict application of rules and inflexible practice, however, with some speaking of

how staff would often maintain routines and set patterns of working despite encouragement to work more flexibly. Despite having the authority and support to work in a more flexible fashion these staff would maintain a degree of rigidity without recognition, or at least open acknowledgement, of the potential negative effects such a stance may have upon patient care. This was particularly noticeable in the narratives when discussing special observations, where there was often high levels of concern noted about fear of criticism from managers about practice. Comments included

> *"if its my job to watch him, then I watch him. No two ways about it"* (SR12)

> *"I don't want to lose my job because I didn't watch him closely enough. Even when he goes to the toilet, I'm there with him. I'm not leaving myself open to criticism or disciplinary action"* (SR3)

The final perceived externally generated pressure upon the respondents was the perception that there was an organisational expectation for them to maintain control. Respondents noted the external provision of security procedures, organisationally endorsed, actively applied, and rigorously monitored and audited. Many believed this to be evidence of the organisation's determination to not only maintain day to day control, but also of the desire to protect the organisation's reputation; to:

> *"not bring any trouble politically."* (SR1)

This notion of organisational safety was seen by some staff as having the potential to adversely affect patient care through the prioritisation of organisational concerns at the expense of patient need. Staff appeared acutely aware of the high political profile of the hospital, the potential for negative publicity in the media, and of pressures from managers to ensure that security or clinical practice did not bring bad publicity. One respondent noted:

> *"they don't want another inquiry do they? It's about keeping the place safe; don't upset things."* (SR10)

Role expectations

This sub-category of 'professional threats' consisted of a number of diverse elements. These were identified as pressure to remain professional, to demonstrate support of colleagues, and to drive the clinical agenda; particularly with those patients in seclusion and on special observations. Respondents highlighted organisational and external pressure to take risks and to reduce the use of seclusion, and noted concerns over having decisions scrutinised by colleagues and management. Two of the most significant role expectations expressed by the respondents were the concepts of caring for patients presenting as challenging, such as those in seclusion and on special observations, and to 'progress' these patients.

The notion of care was often articulated without supporting evidence of what the concept meant to the individual themselves, and was most commonly expressed as a vague ill-defined idea that appeared to be a global term to describe various forms of intervention or interaction with a patient. Staff would almost blandly speak of provision of care, yet rarely identified or expanded upon the specific nature of this care:

> *"the nature of the hospital has changed, in terms of the care provided to seclusion patients."* (SR7)

> *"as soon as they go on obs you need to start looking at getting him [sic] off them"* (SR6)

> *"special observations is a caring intervention; its becoming more prevalent nowadays"* (SR8)

Closely related to this ill-defined concept of care is that of patient progression. Again, this term 'progress' was used significantly in the respondent's accounts when speaking about interacting and intervening with patients in seclusion and special observations. As highlighted earlier, the terminology and descriptions forward by the respondents when describing aspects of 'progressing' patients was often similar:

> *"obviously the plan to discontinue him [out of seclusion] will progress as it needs to, depending upon how he responds."* (SR2)

"we wanted to progress him off his obs, but it was slow going" (SR9)

What appeared to be common to many of the respondent narratives when speaking of patient progress was the indication that when associated with seclusion this was as much a process as a concept. The data suggested that patients' would often be expected to follow a specific course of action or intervention before seclusion would be. This is discussed further when considering the respondent responses to identified threats. This concept of planned progress was less evident in the narratives around the use of special observations, perhaps as nursing staff had less control and say in the imposition and termination of these than in the use of seclusion. The prescription of special observations at the research site is often a multi-disciplinary decision led by medical staff, whereas the commencement and subsequent termination of seclusion, and the care of patients whilst subject to it, remains more in the authority of nurses.

> *"sometimes we don't get a say on obs levels. The care team seem to tell us what to do and then fuck off the ward and leave us to it [laughs]"* (SR4)

> *"to be honest we tend to put them on special obs, but then it's the medics that end them. Its not usually up to us"* (SR10)

Respondents often talked of professionalism, would articulate benevolent values and attitude towards patients, and generally considered themselves to be highly professional in their dealings with patients. Despite articulating their own professionalism, however, as previously touched upon, respondents would often note the behaviour of colleagues to be what they perceived to be unprofessional in some of their interactions with patients. And yet whilst recognising the unprofessional nature of such interactions, these respondents did not appear to consider this to have any negative impact upon the nurse-patient relationship in the long term. An example of this can be seen from one of the staff narratives when talking about the interactions with patients immediately following the commencement of an episode of seclusion:

> *"but I've seen situations before where say a patient might have assaulted another patient or assaulted a member of staff and they've been placed in seclusion, and staff have sort of been at the hatch and said 'fuck you, that'll*

teach you what happens'. But then within a few hours or a few days or a couple of weeks that changes and things become normal again. I keep using the word normal but you know, interactions become sort of non threatening and therapeutic again." (SR9)

Rather than being critical of colleagues, however, the respondents appeared to accept such behaviour towards patients, even though this may have been at odds with their personal expressed value of professionalism. This in itself suggests some staff to be tolerant of the unprofessional behaviours of peers. Whilst some were willing to highlight these behaviours in a confidential research setting, however, what remains unclear is whether these would be openly discussed or addressed within the open clinical setting. This especially given the concern expressed by many of the respondents of the potential criticism of colleagues and peers.

Some respondents spoke of their belief that on occasion such unprofessional behaviour may be self regulated as a means of self preservation; particularly when it is perceived that a patient may be nearing the end of a seclusion episode. This is evident in the following extract from one respondent when discussing how colleagues may have come to realise how their behaviour may have impacted upon their relationship with one particular patient who had a long history of serious assaults against others, and who engendered a great deal of fear in those caring for him:

"*and I think they* [staff] *then realised oh dear, oh dear oh dear he might actually get up and he might remember. He might remember that day that I told him to 'fuck off', or made him wait an hour for a drink, or told him 'fuck off you're down for whatever on your meal; and I think people realised that, erm, and I think it was probably nothing more than their fear for their own lives."* (SR9)

Therefore, whilst respondents would recognise the pressures to maintain a professional attitude and approach towards patients, they would often recognise the failings of colleagues in such areas; recognition, however, often without accompanying criticism. What they failed to recognise or at least openly acknowledge, however, was the potential long term damage or adverse effects upon relationships with patients of unprofessional attitudes and behaviour. From the example above it would also appear that the respondents held the view that

colleagues were able to reflect upon their own behaviour and note concern for their own survival; demonstrating a self focused reflective process rather than reflection based upon moral or professional motivations.

Whilst there was this generalised recognition of the failure of colleagues to maintain professionalism on occasion without an associated criticism, of particular note was how this tolerance and acceptance turned to outward criticism when speaking about the use of special observations. Open criticism of colleagues was evident in several of the staff narratives where they would condemn or blame colleagues for elements of their practice that they felt were putting staff, including themselves, at risk. Criticisms included

> *"with obs you need to stay consistent or the patients will exploit it. Some staff don't seem to get that and think it's a joke"* (SR11)

> *"and he let xxxxxx up to the day area without telling anyone. He cant say no, that's the trouble with him"* (SR6)

> *"I cant understand why some staff cant say no to patients. They just seem to let them get away with anything. When they are on obs they should be telling the patient what to do, not the other way around"* (SR1)

Overall tolerance and acceptance of colleague's behaviour appeared reflective of a more general awareness amongst respondents of the pressure to support colleagues; particularly concerning the use of seclusion. It was heavily associated with the perception that failure to support colleagues may lead to criticism or even ostracism. Yet of note was how such expressions of support would often be explicitly couched in therapeutic rather than personal terms. Respondents would often articulate the importance of supporting colleagues as a therapeutic driver rather than as a self protecting mechanism. An example of such support explicitly couched in therapeutic terms was articulated by one respondent when noting:

> *"But it's a difficult balancing act because I have got to try and keep the clinical agenda rolling forward, and moving forward all the time, but I've got to keep my staff on board."* (SR4)

This was expressed in the context of describing how at times the respondent would have to direct staff to engage with difficult patients and that the need to keep the support of his colleagues was integral to clinical progress. However, a more implicitly stated rationale for supporting staff can be seen in the example below from the same respondent in which he talks of how support from colleagues is often a reciprocal process. This was also expressed in the context of describing working with a challenging patient and yet no mention of a therapeutic driver was either implicitly or explicitly stated:

> *"I look after them. I think if you look after your staff they will look after you."* (SR4)

As highlighted earlier, however, this concept of support of and from colleagues does not always hold true; particularly when respondents perceive they are under pressure to drive the clinical agenda forward with patients in seclusion or feel unsafe through the use of special observations. On such occasions, there appears to be pressure placed upon the concept of mutual support. This was evident with those in positions of authority within the nursing team as evidenced by one respondent when expressing the need to sometimes go against staff opinion:

> *"Sometimes hard decisions have to be made in respect to that. Sometimes you do have to go against the flow. You need to make unpopular decisions."* (SR2)

> *"I took a lot of stick over that. Everyone wanted him to stay in seclusion but I knew we could manage him on obs. It was my decision and I knew it was unpopular, but it was the right thing to do. Not the easiest, but the right one" (SR8)*

Closely related to the drive to change outdated practice was the pressure to take risks and place the patient central to the care process. Respondents spoke of the need to place the patient first and of ensuring transparency in their practice, and yet would not always support this with evidence. They spoke of the need to change culture and practice; even expressing concern that such changes were not implemented quickly enough, but at the same time continued to talk of such change being contingent upon staff support:

"and it's hang on a minute and it's again that balance between changing the culture but keeping people on board and going at the right pace. And I know the pace hasn't been fast enough at times Des, it certainly hasn't been fast enough for me." (SR4)

With this recognition of the often slow pace of change, however, also came the realisation by respondents that often significant changes can prove difficult due to the reluctance of some staff to take risks, or to think creatively given the pressures to conform to expected behaviours; the pressure from colleagues to maintain existing practice. This concern was articulated by one respondent who acknowledged the difficulty in working creatively with one particularly treatment resistant patient in seclusion:

"and staff like to get into a routine don't they. That's one of the difficulties in taking risks and doing things outside of the box." (SR2)

This was in response to staff reluctance to change usual practice and what the respondent saw as a lack of motivation to progress the care of a patient who other staff generally perceived as highly unpredictable; one who instilled a great deal of fear and anxiety. Such reluctance to progress some patients above others was a common theme articulated by staff respondents, who noted how on occasion they would have to be more assertive and directive with colleagues when attempting to make progress with patients their peers saw as particularly challenging, unpredictable and dangerous. This was noted by one respondent, who as earlier noted, commented:

"sometimes I do go down and have to say 'right come on' and sometimes they do need a bit of a shake up. 'Come on bloody hell I'm giving you the tools to do the job and you are not doing it. 'Get xxx up'." (SR4)

and another, when talking of the need to instruct staff to end a patient's seclusion episode, noting:

"*at times you just have to make hard decisions and go against the flow. You need to make unpopular decisions and tell them to get someone up, even if they don't want to."* (SR11)

This would indicate that at times despite concern over potential criticism from colleagues, some respondents would challenge and direct practice to progress

patient care, even with the most challenging of patients; those who cause staff most concern. The data suggests that this challenge to practice was largely undertaken from those respondents whose professional role required them to demonstrate leadership, and placed them in a hierarchical position, although as highlighted earlier, this challenging of practice and of colleagues was often accompanied by feelings of increased anxiety.

The final element in this sub-category of role expectations is the concern that decisions will be scrutinised externally either by management or external bodies. The fear of being blamed was of concern to many of the staff respondents who felt that at times it impacted upon their decision making; often around the use of seclusion, but particularly around the use of special observations. Respondents noted how at times this would prevent creativity and help in maintaining practice status quo. This would in turn give rise to frustrations in those who appeared to genuinely wish to 'progress patient care', but felt constrained from doing so through organisational inspection, monitoring of practice, and the belief that managers were critical of failure at times.

> *"sometimes you want to do things, but there's always that doubt that if it goes wrong the managers will crucify you. There's still a blame culture here even though they say there isn't"* (SR12)

> *"I don't want to get into trouble. Nobody does, so why take a chance with his obs levels. I would sooner be criticised for 'over doing' it than letting him hit someone"* (SR3)

3.8.2 Psycho-social stressors / threats

The second main category supporting the core category of perceived threats relates to those stressors and conflicts that impact upon psycho-social functioning (see Diagram 16). This category consists of several sub-categories that reflect perceived stressors and threats.

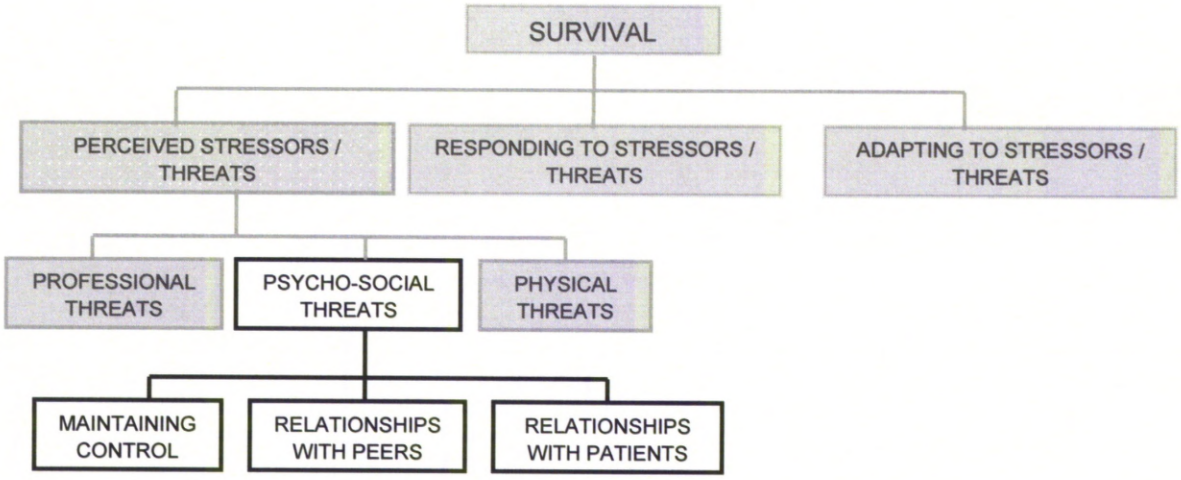


Diagram 16: Sub-categories of psycho-social stressors/ threats

These relate to the pressure to maintain control of the clinical environment; to feel secure in the tasks and duties undertaken and assigned, and are often reflected in the respondents interactions and relationships with both colleagues and patients alike. The following sections explore these sub-categories along with their respective constituent elements.

Maintaining control

A significant issue for the staff respondents in the undertaking of their role is the pressure to maintain control. This concept of control appears to be deeply entrenched in the staff culture and was expressed in the staff narratives as being important in the ability to function effectively within such a highly stressful environment. Staff would openly speak of their concerns about the maintenance of control, the feeling of safety that this control gave them, and the stress and anxiety felt when this was undermined. Some respondents appeared to gain a sense of relief and comfort from having rules and procedures rigidly applied. One spoke of this relationship between control and safety when recounting an event with a patient on special observations who was challenging the parameters of his care plan:

> *"at the end of the day it's not all about, you know controlling everything, whether someone can watch the TV or whether they can have room access, but it's about feeling control but in a safe way. I think people felt like we didn't have a handle on this, and thus we're not completely safe with it, and we started getting anxious."* (SR9)

The data suggests that this issue of control is a significant element in many of the tasks required of staff in the undertaking of their duties. Respondents often felt the need to remain in control of the care planning process and appeared to adopt the principles of negotiation and collaboration only as long as it was on their terms; as long as patients were compliant and not challenging of staff. They would often advocate the virtues of collaborative care planning and staff-patient negotiation and yet would speak of this in ways that would suggest that on occasion this would be a staff led and not a truly negotiated process. One respondent noted this willingness to work with patients, but indicating that the staff would be the decision makers in the process, highlighting:

> *"we have to work together with this...obviously we're not going to be led by the patient; but we will make appropriate decisions."* (SR6)

Respondents appeared to perceive the challenging of their authority as taking many forms, be it direct or indirect behaviour. However, the behaviours that appear to be of greatest concern are the challenges arising from non-compliance; often defined by the respondents as patients challenging their care plans, challenging the decisions of staff, or simply not adhering to staff requests or demands of them. Whilst these behaviours are often tolerated to a degree in their many forms during non-threatening everyday interactions between the respondents and patients, the data suggests that anxieties and concerns are heightened when these non-compliant behaviours arise at times of increased patient arousal or agitation.

At such times of potential interpersonal conflict between staff and patients, the respondents will often feel threatened by non-compliant behaviour, believing it at times to be deliberate defiance and often a threat to their professional, psycho-social or even physical functioning or wellbeing. The staff narratives suggested that at times the perceptions of patient motivations and behaviours was associated with the nature of the relationship that the staff holds with the patient and whether the specific patient is liked or disliked within the ward community. This was seen in the following example where one particular patient, liked by many of the staff, appears to have his illness driven behaviours tolerated above and beyond that tolerated of other patients. This also appears to be the cause of some conflict between the staff

who like the patient and those who do not share this perception and are not supportive of the tolerance shown towards his behaviours:

> *"I mean there are some patients that you don't like, you know? naturally don't like. And some patients don't like you. But in the instance we are talking about he is well liked. His illness is over tolerated in terms of presentation sometimes and I think that causes conflict on the ward in terms of management."* (SR1)

It is not just this over tolerance however, that appears to be the cause of potential conflict. The data suggests that on occasion, where staff are engaged in potential conflict with patients, they may misinterpret the intentions of the patient; considering their actions as hostile and threatening, when perhaps this is not always the case. An example of this was given by one respondent when speaking of an incident with one patient on special observations. The respondent highlighted how the general staff perception of this patient was one of being intimidating, hostile, with a history of extreme violence, and having a reputation for extreme pushing boundaries. In the example given the respondent explained how in response for not being allowed a light for his cigarette, the patient sat passively on the floor in protest:

> *"he claimed other people didn't give him a light, but we were thinking we were almost rewarding bad behaviour. For want of a better word somebody put it that it's like giving a dog chocolate for taking a shit on your couch."* (SR10)

The respondent's perception of the staff reaction to this passive non-compliance was that it was viewed negatively and that a conciliatory staff response was seen to have been akin to rewarding a dog for defecating on furniture. This perception of the patient as a dog, somehow sub-human, is not isolated to this incident, however, although the likening to an animal was not a commonly expressed theme. This failure to recognise patients as individuals was evident in the depersonalisation of patients in seclusion; where those patients in seclusion would become 'the seclusions'. This issue of depersonalisation is discussed further when exploring the staff responses to threats.

It is not only non-compliance in the undertaking of special observations that gave cause for concern to the respondents, however. The respondent narratives

suggested that patients in seclusion are also required to show compliant behaviour, to demonstrate a willingness to engage with staff, to adhere to requests and to behave in a manner expected of them by staff. Non-compliance when in seclusion is often interpreted as an indicator that patients are not ready to have their seclusion episode terminated, and can give cause for concern to staff having to enter the room to engage with the patient and provide care. One respondent spoke of the fear experienced at times when entering the seclusion room with some patients, noting:

> *"most of the time you are not bloody confident [laughs]. A lot of times you are going into someone who's upset or has been disturbed, there is a high level of anxiety shall we say [laughs]. You are going in trembling [laughs], your teeth are chattering and things like that...I think the thing is to try and be as in control of it as you can be."* (SR7)

It is noted here that despite recounting incidents in which there is clearly a great deal of anxiety and trepidation on the part of the staff, the recounting of tales were often undertaken with a degree of humour; a concept that will be discussed further when exploring adaptations to threats.

Relationships with peers

As previously highlighted, the respondents generally hold their relationship with peers and colleagues in high regard; particularly when considering the use of, and managing patients in seclusion. The staff narratives suggested that at such times of increased stress and anxiety awareness of colleagues concerns and views are heightened and the fear of ostracism from colleagues can place pressure upon them when making decisions. The decision as to whether to seclude or not seclude, or how patients are managed whilst subject to a seclusion episode, appears to be adversely affected by the pressure to conform to the majority view; the usual methods of managing such situations and such patient behaviours. The data suggests that on such occasions some respondents appear to become more acutely aware that their actions may well be judged by colleagues, particularly if interventions go awry. This was a common cause of concern for several of the respondents; adding to the conflict between competing demands. One respondent noted his awareness of disquiet amongst his peers following one particular incident:

"when I came into work the next day there were looks, and I said to xxx 'what's the matter'. 'Oh you went down opening doors and getting people out of seclusion'." (SR6)

This example suggests that at times the reactions and behaviours of individual staff may not always be driven by altruistic, patient centred motivations, but also in part by concern over the need to display solidarity with peers; to conform to expected behaviours and not expose them to undue risk. This concept of placing staff first, however, would appear to be motivated more from intrinsic considerations than any true regard for the wellbeing of colleagues.

The staff respondents recognised the fear inducing nature of intervening in the management of patients in seclusion, however there was often a sense of camaraderie within the staff group; a bond that united them to work together towards a common goal. Several possible reasons for this were highlighted in the data; namely the finite nature of the intervention, the availability of significant numbers of colleagues to assist, the perception that they all faced the same risk, and the notion that they were working in a co-ordinated manner to manage a difficult situation. This in itself would suggest that at times of intervening in a situation with a challenging or violent patient staff will often provide mutual support to each other and place their own needs above that those the patient.

Despite these occasions of staff appearing to work in a co-ordinated, supportive manner to achieve a goal, some respondents commented on the challenges they perceived in helping patients. They spoke of how at times these challenges may simply be a result of patient's lack of response to treatment or clinical relapse, whilst at other times from reluctance by colleagues to share the same vision:

"speaking openly and honestly sometimes it feels like you are banging your head against a brick wall sometimes. You don't seem to get anywhere. You feel sometimes you are really running hard just to stand still." (SR6)

This lack of collaborative vision from colleagues would not only raise respondent's concerns, but also had the potential to adversely impact upon their relationships with patients; potential conflicts that will be discussed further in the following section.

As highlighted earlier, however, whilst respondents would often speak of a comradery with colleagues over the use of seclusion, the use of special observations would at times indicate less of a bond and more of a self serving and self preserving attitude of staff towards their colleagues. Whilst teamwork and collaboration with colleagues was considered important in the use of seclusion, the same did not appear to hold true for the use of special observations. Comments by staff included

> *"when I'm on obs I'll do what I think is right. If some staff don't like that then tough"* (SR7)

> *"it gets on my nerves sometimes when others try and tell you how to manage the obs. They wont do it themselves, but they'll sit there and whinge at how I'm doing it"* (SR11)

This particular relationship between staff will be discussed in detail when discussing responses to threats.

Relationships with patients

This section will highlight the stressors and conflicts the respondents experience as a result of their relationships with patients. These stressors appear particularly significant to them at times of heightened anxieties, such as when interacting with patients during periods of seclusion or special observations. The anxieties appear to arise as a result of the pressures to engage in collaborative and negotiated care planning at times of conflict, from competing demands between colleague and patient expectations of them at such times, and from potential conflicts in providing care and engaging therapeutically whilst maintaining control and authority.

The data suggests that the issue of collaboration and negotiated care planning can prove particularly challenging at times when patients are in seclusion or on special observations. Both interventions were often perceived as controlling and staff led approaches, which could conflict with the concepts of collaboration and negotiation. The example below highlights how one respondent perceived

collaboration to be problematic at these times, and demonstrates the concerns that this can cause:

> *"it's not always easy to negotiate when they go in because they are still angry, you know? [laughs]. They sort of just shout at you a lot [laughs]. No, seriously, it can be hard because some staff don't like it when you start making decisions on your own or with patients without consulting them."* (SR7)

This need to collaborate and negotiate care with patients was noted to arise not only from organisational pressures, but also from acknowledgement of this as an integral component in the building of trusting therapeutic relationships; a core nursing function. However, further anxieties were experienced by respondents in their relationships with patients at times of potential conflict, such as when providing care for patients in seclusion or on special observations. Some respondents noted how on occasion they found patients looking to them for support, whilst they simultaneously experienced pressure to conform to staff norms and to side with colleagues. This can be seen in the example below regarding the use of special observations:

> *"it was a difficult time to be honest. There was pressure from the care team to go slowly, but xxxx wanted to run, so to speak. He just wanted his obs lifting as he saw that as the ultimate show of trust in him. As his primary nurse it was a strain on our relationship to have to get him to slow down. Sometimes he took it as me being funny with him"* (SR2)

and in this example which indicates a degree of frustration and unease in the forwarding of care with this patient, through recognition of the potential conflict between working with the patient and at the same time keeping colleagues happy. It would appear that these competing demands may create significant strain upon staff and patient relationships.

> *"it didn't really sit well Des, you know? I always try and work with patients and sometimes I have to hold back a bit, yeah? Sometimes I might want to get someone up and they are up for it. We have talked about it and what they need to do, but then you always have to think of the other staff and make sure they are on board with it."* (SR8)

One final issue from the staff narratives that suggested a potential stressor for the respondents in their relationships with patients was that of the recording of

incidents and subsequent patient behaviour and response to what was recorded. The staff narratives suggested that some respondents felt that further conflict or damage to therapeutic relationships can occur on those occasions when patients do not agree with staff perceptions of an incident or subsequent appraisal of patient behaviour. This can be seem in the example below in which the respondent recalls how one patient withdrew from therapeutic engagement with specific staff on account of what was written about his involvement in an incident that had resulted in his seclusion:

> *"he wasn't happy with what was written. He seemed to blame me and xxx, his primary nurse. He eventually came round, but he withdrew from us for a while. We had to stick with it, but it was worth it."* (SR6)

3.8.3 Physical stressors / threats

The risk to physical functioning and wellbeing is the final category to underpin the core category of 'perceived threats'. This relates to the fears and concerns of nursing staff for their own physical safety and wellbeing in the face of perceived danger from patient aggression; often during situations in which seclusion or special observations are being used or considered (see Diagram 17). There are several elements to this category; namely the perceived threat of imminent violence, perceived increased risk due to the drive to reduce seclusion, awareness of one's own physical vulnerability, and awareness of oneself as a potential target.

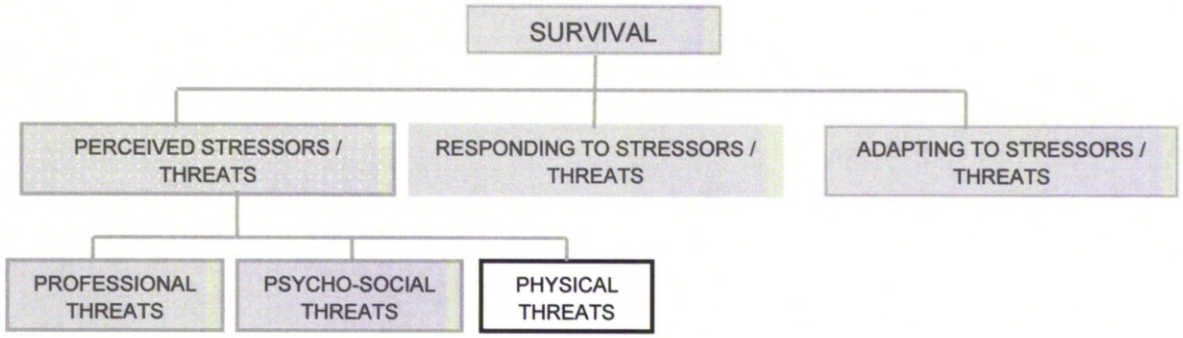


Diagram 17: Physical stressors / threats

Respondents would often talk of their awareness of the dangers of the role they performed, noting past patient behaviours and physical prowess as indicators and reinforcers for their concerns. They would often recite examples of previous incidents with patients, at times incidents they had only been made aware of via

third hand information, and would attempt to highlight the dangerousness of the patient to the researcher. This appeared very much to be a form of validation for their concerns; an attempt to rationalise their fear as natural and understandable:

> *"He is deemed more of a threat because he is a powerful, 18 stone, quite muscular fella, who is intimidating, hostile. He's got behaviours of assault, he's been assaultative all of his life and that's his coping mechanism."* (SR3)

> *"in the past he has smashed his room up requiring the use of C&R Level 3 response team which is protective equipment, smashed up offices and assaulted people and even electrified doors. He is probably one of the most strongest patients in high secure services here at the minute."* (SR6)

When speaking of past incidents in which they were concerned for their own safety, respondents would often use humour in the recounting of events. This appeared to be a form of 'gallows humour'; perhaps a means of minimising the impact upon them whilst still highlighting the perceived danger. Examples of this can be seen in the following example given by a respondent in which the statement was followed by laughs:

> *"What other job do you come in on a daily basis and someone says I am going to kill you, when I get out of here I am going to kick fuck out of you. And regularly have the opportunity to do it."* (SR10)

In this example the respondent is emphasising his perception of his role as being particularly fraught with danger, and emphasises this through the use of quite emotive language to convey this fear and concern. Throughout the interview with this respondent he appeared eager to convey the perceived dangers inherently present within his working environment and appeared acutely concerned for his own personal safety in his engagements with patients.

Alternatively, however, other respondents, whilst still recognising the dangers present within their working environments would express a more reflective, calmer and less concerned attitude. This was evident with one particular respondent who had been talking about having been assaulted whilst supervising a patient on special observations. When asked whether he had reflected on the decision to get in close physical proximity to the patient. He laughingly commented:

"No, I was too busy getting the blood out of my shirt." (SR8)

This was expressed more casually than sarcastically, however, with the staff attributing the event to the patient's illness. This particular respondent did not offer any supporting evidence to emphasise the perceived dangerousness of the job, and demonstrated a degree of acceptance of such behaviour when caring for disturbed patients.

The data did suggest that the staff respondents appeared to be more acutely sensitive to the threat of imminent violence when undertaking special observation, or when supervising patients during seclusion episodes than in usual everyday practice. One respondent talking about the special observations of one patient with a history of smashing segregation cells in prison and assaulting prison staff jokingly noted:

> *"I remember when xxx used to come out of his room and there would be six or seven staff around and he would joke and say "fucking hell has a big job broken out"; but he clearly knew what it was about."* (SR7)

The respondents certainly appeared to appreciate the potential for violence in the undertaking of their duties and would often talk of the increased risk associated with the perceived drive to reduce the use of seclusion. One respondent noted the concerns of staff when speaking about the pressure to get one particular patient out of seclusion:

> *"a lot of the staff I think were of the opinion of he's never getting up [getting out of seclusion] this lad, he's never going anywhere. And do you know why he's not going anywhere? because he's going to kill one of us. When he hits someone he's going to kill someone and we don't want to be here the day that it happens."* (SR10)

This perception that some patients could inflict serious or even life threatening injury was often talked about as a very real concern. Again, however, this was often expressed with a degree of humour. One respondent smilingly spoke of an incident with a particularly strong and violent patient who historically instilled a great deal of fear in staff. He spoke of how the patient was escorted by staff to seclusion following an increase in his hostility, noting:

"Well at this stage there is probably about 20 staff, because we got a response from other wards, so it was like assault on precinct 13 really, like, you know? And you've got this guy walking through the melee of 20 staff plus, and it's highly charged with all staff waiting; all on red alert, ready to go like you know. If he farted or something they'd have probably jumped on him or something. It's just, that's the way he is; that's what he invokes in people." (SR1)

This perception of safety in numbers was often expressed by respondents, who felt less threatened whilst patients were in seclusion. This contrasted with awareness of their own vulnerability when dealing with challenging patients; particularly those on special observations. Certainly the seclusion process places a physical barrier between staff and patients and hence lessens the direct threat to physical wellbeing. Special observations, however, by their nature remove the physical barrier and place staff in a position of direct physical proximity to patients. The data suggests that this is a situation that can be of concern at times as evidenced in the following example from one respondent:

"we've got a guy who's very dangerous, hostage taker. I've seen him attack people in the prison system, I wasn't involved in the xxx incident on xxx ward, and I've also seen him attack people throughout the prison system, I've seen him with the 5 biggest stockiest prison officers they could find and they were genuinely terrified of this guy. But there's me who's on a 1:1 with him." (SR4)

This awareness of one's own vulnerability can also present itself when the respondents are tasked with entering the seclusion room and engaging with the patient. One respondent noting:

"Well there is always that bit of apprehension when you open that door because no matter how many guarantees you've got off someone that they are not going to assault you when you go in, sometimes it can go the other way." (SR5)

Another respondent laughingly remarked about special observations:

"Strangely we tell them if they were on level 3 obs because we were concerned about them, but when they come out and there are four people standing around them we don't tell them that's because we are concerned about ourselves." (SR8)

Whilst the staff narratives suggested that one's own physical vulnerability does not appear to be of particular concern in the undertaking of everyday tasks, or even whilst a patient is locked within a seclusion room, it did highlight that this becomes significant when respondents were assigned to supervise and engage with some patients on special observations; particularly those whom they perceive as challenging and unpredictable. This concept of unpredictability was of specific concern to many respondents; one noting:

> *"There are other patients that I wouldn't go within 20ft of, on special observations. Because some people don't give you that fore warning as I found out with that guy I was playing cards with that day, and he smacked me in the face. It came from nowhere."* (SR1)

As pressure increases to engage with the patient in seclusion by entering the room or supporting the patient out with of the seclusion room, however, concerns and fears for personal safety again surface; as the physical protective barriers of a seclusion room are removed and the interactions between staff and patient are played out in an open environment.

It can be seen, therefore, that the respondents perceive a number of threats within their working environments. A high dependency ward within a high secure environment presents many challenges to them in the undertaking of their duties. These challenges can impact upon professional integrity and standing, working and social relationships with peers and colleagues, and professional interpersonal relationships with patients. It is these challenges that impact upon how they perceive their environment, and can contribute to feelings of concern, fear, trepidation and uncertainty. The respondents perceive their practice to be under scrutiny by not only the organisation, but also by external agencies, peers and even patients. It is these fears and concerns that can heavily influence the attitudes and approach adopted by staff in undertaking their roles, and in return affect the quality of care provided and the level of professionalism displayed and maintained. These influences are particularly prevalent in the care and management of patients in seclusion or subject to special observations as the respondents often perceive these as times of potential conflict, and times of increased scrutiny of practice and individual decision making.

It was when describing the undertaking of special observations that the staff respondents displayed most concern for their own physical safety and wellbeing. The face to face contact with the patient, often without the immediate supportive backup that additional staff provided, appeared to give rise to feelings of vulnerability and heightened stress and anxiety. This in itself gives rise to implications for future practice and potential staff support requirements; particularly given the emerging use of special observations as an adjunct to and possible replacement for the use of seclusion.

Allegiance to colleagues appears to play a significant role in how the staff respondents not only perform their role, but also in the degree of anxiety and concern experienced. The fear of ostracism or rebuke can affect decision making and lead to conservative, risk averse behaviour at times; particularly when dealing with challenging patients and those in seclusion or subject to special observations. The commitment to peers over and above patients can place strain upon the staff-patient relationship at times, particularly when faced with a dyadic encounter or conflict situation in which the patient may have expectations upon the staff based upon their own perception of a trusting and therapeutic relationship. The respondents recognise this as a potential stressor and the cause of significant anxiety and tension.

The staff narratives also demonstrated the anxieties experienced by the respondents when faced with challenges to their authority; patient non-compliance and the questioning of rules, staff demands and expected behaviours. The data suggested that on such occasions staff can experience heightened levels of concern resulting from the fear of losing control of the situation, of having one's position questioned, and of being seen in a negative light by either the organisation or peer group. This fear of losing control of encounters with patients on a cognitive level appeared closely associated with the respondent's perception of professional self, and of potential damage to ego and feelings of professional worth and status. This appeared particularly evident during encounters that may lead to the use of seclusion or special observations, or in the management of patients already subject to these practices.

It has been shown, however, that the respondents not only experience concern and stress over potential damage to ego, social status or professional standing. The staff narratives suggested there is often a very real concern for one's own personal safety in the face of heightened patient arousal, agitation and aggression. Members of staff will often feel intimidated by patient behaviours, reputations, history of violence and physical presence and size. The respondents would often fear for their own physical wellbeing, especially at times when physical intervention may be required or when patient behaviours are likely to escalate to actual violence. At such times they more readily identified themselves as potential targets and became more aware of their own physical vulnerability and limitations. These Interactional encounters with patients at times of heightened emotional arousal presented the respondents with still further cognitive and emotional conflict as they had to reconcile the urge to protect one's own physical wellbeing and safety whilst at the same time acting in such a way that inspires confidence, reassurance and acceptance in his colleagues; to act in a way commensurate with behaviours expected of them by colleagues when faced with challenging patient behaviours.

3.9 Responding to stressors / threats

This leads to exploration of the second core category underpinning the theory of survival; the response to the perceived stressors and threats, and how nursing staff react to the pressures, conflicts and stressors faced when managing patients in seclusion or on special observations.

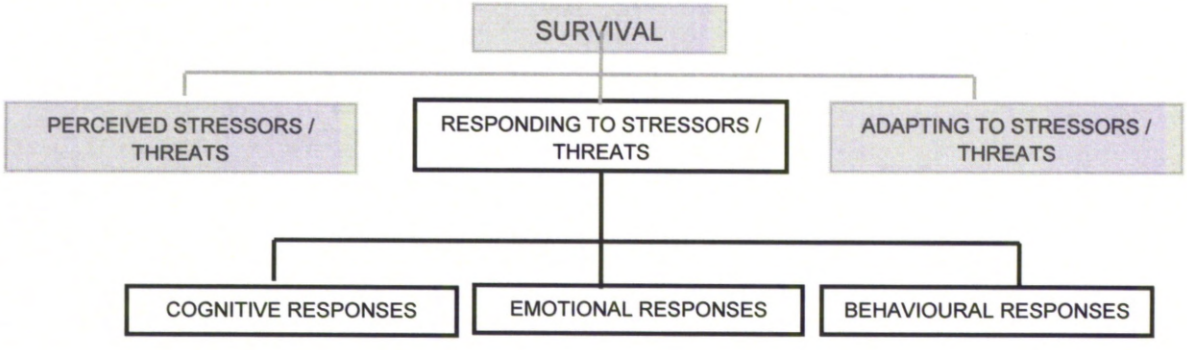


Diagram 18: Sub-categories of responding to stressors / threats

The over-riding focus of the staff responses to their perceived stressors or threats was always to protect the self; to play it safe. This would invariably lead to

defensive practice and to cognitive, emotional and behavioural responses. Each of these three main categories comprised a number of specific elements or sub-categories that contributed to this defensive response and will be explored in detail in the following sections.

3.9.1 Cognitive responses

Cognitive responses appeared to provide the staff respondents with psychological protection from the stressors they experience when faced with challenging and stressful situations, assisting in how they cope with the pressures and reduce anxieties.

One such defensive strategy was highlighted earlier by one respondent when speaking of the rigid application of policy; noting that if they stick to the rules then they know where they stand. Whilst this has the potential to stifle creativity and at times hinder patient progress, the staff narratives suggested that from a staff perspective it helps keep them safe; professionally, psychologically and physically. Integral to this concept of defensive practice is increased risk aversion; sometimes consciously adopted but at other times appearing to be a more subconscious psychological mechanism. One respondent spoke of how fear impacted upon the risk process when noting:

> *"when people get frightened I think they perhaps over assess risk more than we should."* (SR7)

with another commenting:

> *"If people don't feel safe then they won't take risks will they? Staff have got to feel safe to be effective, otherwise nothing will get done."* (SR10)

This 'playing it safe' appeared to demonstrate an association between safety and control, with individual staff respondents perceiving that their safety was contingent upon their remaining in control of situations, and that this control was to be found in familiar practice. Change was at times perceived as increasing risk in that it may give rise to unexpected or unfamiliar situations which could raise anxieties by taking them out of their comfort zone; that area of practice they feel in control of and feel safe working within.

This was particularly evident when discussing and describing the use of special observations, where several of the staff respondents spoke of the need to maintain observations in line with the organisation's policy in order to stay not only professionally safe, but also physically safe. Comments included

> *"its when you start cutting corners that the risks increase. They are on obs for a reason. Forget that and you'll end up getting hurt"* (SR1)

> *"I don't understand why some staff take risks when on obs. Don't they realise how vulnerable they are. One slip up and they could get injured. I've fuckin seen it Des"* (SR4)

A further cognitive mechanism adopted by respondents appears to be the de-humanisation of the patient when in seclusion or on special observations. Staff will often talk of 'seclusion patients', 'the seclusions', or 'the obs' at the expense of speaking about the individual patient. Examples from respondents regularly highlighted this depersonalisation; speaking of patients in seclusion or on special observations as a distinct group as opposed to recognising them as individuals. Whilst the respondents would often talk of 'patients' as a collective group, the use of the term 'seclusions' and 'obs' appeared to be used to distinguish and depersonalise; it served to marginalise, categorise and stigmatise:

> *"for example at our meeting this Friday its going to be devoted totally to talking about the long term seclusions we have got and how we manage them."* (SR6)

> *"I think there is a health debate that goes on week to week around the seclusions."* (SR10)

> *"sometimes it gets to you always having to work with 'the obs' patients.* (SR8)

This depersonalisation appeared to be associated with a mechanistic approach to undertaking tasks, with respondents often talking of routines and how these would often reduce anxiety as it avoided grey areas. By compartmentalising, interactions and engagements could be reduced to tasks and jobs; and in doing so offer a degree of protection from the cognitive and emotional stressors of the situation. This element of staff valuing routine can be seen in the following example from one respondent when commenting:

"And staff like to get into a routine don't they. That's one of the difficulties in taking risks and doing things outside of the box. They like to, you know like to do things in a certain way all the time; sort of 'this is what we do, and they are in seclusion so we do this and do that.' (SR2)

As noted earlier, in addition to this depersonalisation often comes a reluctance to engage with patients; particularly if one has been involved in the incident giving rise to seclusion or if placed on special observations with a patient with whom the relationship is strained. Several respondents talked of friction between nursing teams as to how and when to terminate a seclusion episode, with the team involved in the incident, perhaps having been involved in a violent episode, often more reluctant to end the episode at the speed considered appropriate by those not directly involved. This was highlighted by two respondents when noting:

"if an incident happens on one group they are going to be reluctant to getting the patient up, you know?" (SR3)

"it's very easy once you have someone locked behind a door to leave them." (SR2)

and highlighted similar frictions in the use of special observations with comments such as

"it depends who they are to be honest. Their reputation will often dictate when they come off obs" (SR7)

"sometimes there is a bit of a debate [laughs] between the care team and the nursing staff over obs levels. They don't always see it from our point of view" (SR12)

3.9.2 Emotional responses

In addition to the cognitive responses to perceived threats are the emotional responses displayed by nursing staff in their attempts at protecting themselves from the stressors and pressures present when dealing with challenges during the undertaking of their role. Many respondents spoke of feeling intimidated by patients, particularly at times of increased patient arousal, agitation, hostility and challenging of authority.

This concept of intimidation appeared to resonate throughout the staff narratives, with many of the respondents noting patient size and history of violence as key determining factors in whether they felt intimidated, whether they were concerned for their own safety, or whether they experienced increased levels of anxiety. One respondent spoke of this when noting:

> *"xxx is intimidating. He's over 6 feet tall and 20 stone with aggressive tendencies, and to a lot of people that's intimidating in itself. If he was yyy's size who is about 5 foot 10 and 7 stone almost, staff wouldn't be as worried even though yyy has murdered a member of the public. Yyy is even threatening to murder somebody else at the moment but nobody thinks twice about opening the door and saying come on yyy do you want a shower."* (SR10).

Another staff spoke of the almost constant fear he experienced in dealing with patients in seclusion when noting:

> *"Yes, it's quite a scary time, especially with some of the guys in there. On some of the wards you tend to get threatened quite a lot, so it worries, it's on your mind. The word I would use is scared. If anyone says they are not scared they are liars."* (SR6)

This feeling of fear and heightened levels of anxiety was common throughout the staff narratives. They clearly found their work environment to be highly pressurised with significant challenges to their safety and wellbeing. This would be particularly true at times when faced with direct patient aggression and hostility. One respondent summed this up as:

> *"You are shaking like a shitting dog (laughs), because you are trying to remain calm, and you can't let yourself be seen as scared. But of course you are scared, there is this man who is quite strong that has a history of hitting people, and you happen to be the person there."* (SR5)

Respondents would often talk of experiencing physical symptoms of anxiety whilst in work, including sweaty palms, dry mouth and butterflies in the stomach. They highlighted how they would often be in a heightened state of arousal as patient hostility increased and when sensing an incident to be imminent.

This heightened state of arousal was particularly noted at times when assigned to undertake special observations, with the physical proximity to the

patient considered particularly troubling to some respondents in the absence of the protective barriers offered with seclusion. At such times patient hostility and unpredictability become more concerning and staff apprehension increases. Some respondents noted

> *"sometimes you have to get really close, you know? And that's when your heart starts to pound. When they are in striking distance you always expect a punch"* (SR4)

> *"its got to be the worst job on the ward. You're just standing there sometimes waiting for this guy to strike out. If he's within arms length then you are certainly aware of the potential for a punch or butt"* (SR12)

However, experiences of fear and anxiety were not confined to the working environment, with respondents commonly speaking of concern for one's own safety causing anxiety even out of work. One respondent spoke of his increasing anxiety when attending for duty following a period of leave from work:

> *"Every time you come on duty you get butterflies. But you keep walking [laughs], you have to, haven't you? I think the biggest thing is if you have three or four weeks off, you do feel as you come through the gate your stomach turn over slightly. Because you don't know what you are walking in to, do you?"* (SR6)

Others spoke of the impact following a span of duty, noting:

> *"I know members of staff who would go home and say they honestly couldn't sleep at night because they were worried about coming back in the next day."* (SR10)

> *"staff did mention that they couldn't sleep last night and were worried sick coming in because we're going to have to get xxx up; and they were fretting."* (SR9)

These pressures and concerns appeared very real for the respondents, several of whom experienced a genuine fear for their own safety and concern about the following days work. At times these concerns for safety would lead to an emotional response of relief when incidents are resolved or when able to physically withdraw from the patient's proximity. This would offer them the opportunity to emotionally disengage and provide emotional relief from the stressors experienced

in dealing with face to face aggression and hostility; providing a period of respite before having to re-engage again.

Respondents would openly speak of how at times they would breathe a sigh of relief after an incident and where a patient was secluded. This would also hold true when patients in seclusion would be returned to their locked room following a period of assessment in an open area, or when patients on special observations would return to their room for the night. One respondent summed this up as:

> *"you're anxious all day and you never know what's coming, and you just try and make it through the day. Everyone would go 'ahhh' and just breath a sign of relief because you've made it through the day."* (SR7)

It was previously highlighted how staff relationships would often appear closely knit and mutually supportive. However, as previously highlighted, there are times when, as an emotional response to perceived threats, there is open criticism of colleagues, with the usual tight bond appearing to fragment somewhat.

It was noted earlier, that this was particularly evident when exploring the experiences of special observations. When undertaking these observations the respondents would often become more acutely aware of the lack of immediate physical or psychological support from colleagues and of their own vulnerability with respects to having to deal with patient challenges without this support. At these times they would often become more aware of their own physical vulnerability and the need to enforce security procedures and maintain control in a situation they themselves found uncomfortable and anxiety provoking. These pressures to undertake what they perceive to be an enforcing and controlling role in the face of perceived increased risk, would often conflict with the pressure to conform to staff norms and to be supportive of colleagues. This in itself giving rise to increased anxiety and open expressions of criticisms of colleagues.

Criticisms were often expressed when respondents considered the actions of colleagues to be increasing the risk to themselves; examples being when other staff would not rigidly adhere to care plans, or would actively engage in activities with the patient rather than passively observe and supervise. One respondent noted how he would regularly receive criticism from colleagues as a result of his engagement with patients on special observations; colleagues who considered his

actions to be increasing risk when encouraging the patient to come out of his room into the ward community:

> *"some staff thought I was mollycoddling him because I would play table tennis with him; they thought I should leave him in his room."* (SR8)

As previously noted, many of the emotions expressed by the respondents appeared to be a result of heightened anxiety and concern for their own safety. Whilst they would often express altruistic values and caring attitudes, what was evident from the narratives was how intrinsic values and beliefs could be held secondary in the face of perceived danger and risk. On occasions, such as when dealing with some particularly fearsome patients on special observations, instinctive protectors would engage and behaviours would be motivated more by personal survival than by recognition of patient, colleague or organisational need.

3.9.3 Behavioural responses

The final category underpinning the core category of responding to stressors and threats is that of behavioural responses. These relate to the specific actions taken by nursing staff that serve as protectors from the stresses and pressures faced. The narratives suggested that at such times staff will often rely on the use of restrictive practices such as seclusion or physical restraint either in response to their own concerns or those of their colleagues. On other occasions, however, specifically around the use of special observations, staff may lie, deceive, appease, and even avoid patients as a means of protecting the self.

This consideration of the use of restrictive practices such as seclusion or physical restraint appears to be closely related to the defensive practice evident in respondent's cognitive protecting mechanisms. It appears similar to a siege mentality in which it becomes easier to deal with the problem in the ways in which they are familiar and which maintain a sense of control and authority, than attempt to reconcile in ways in which status, esteem or physical wellbeing may be placed at jeopardy. Rather than the use of restrictive practices being the last resort, it would appear that at times they would almost become the interventions of choice when faced with situations of extreme pressure or threat to professional, cognitive, social or physical functioning.

Not only does it appear that individual staff consider the use of restrictive practices when faced with threats to functioning or safety, but often patients in seclusion will also have to demonstrate an element of compliance greater than that often tolerated when not subject to a seclusion episode. The placing of a patient in seclusion appears to change the perceptions of staff in that there often becomes a greater requirement for compliance than would otherwise be required. Whilst this may appear punitive, there was no evidence in the narratives to suggest that this punitive element was recognised, acknowledged or consciously considered by staff in the lengthening of a patient's time in seclusion. However, it did appear to stem from a behavioural response to maintain control to lessen individual and collective anxieties. This concept of the need for increased compliance was succinctly expressed by one respondent when noting:

> *"and xxx sometimes does things when he is out of seclusion that we deal with, and we manage it. But once he is a seclusion patient 'oh no, we are not tolerating that'. Does that make sense?"* (SR2)

The use of restrictive practices such as seclusion, and the requirement for increased compliance as a means of protecting threats to functioning and wellbeing, differs somewhat from the behavioural responses adopted when undertaking special observations. Here, the respondents noted how staff will often use different mechanisms to cope with the pressures and stressors faced by potentially intimidating, hostile, or challenging patients; strategies in which staff may deceive, appease or attempt to physically avoid the patient dependent upon the level of perceived threat. The lying to patients will often take the form of deflecting responsibility for restrictions in an attempt to diffuse any potential patient anger or challenge to restrictions placed upon them as part of the special observation episode. An example from one respondent spoke of how at times he would blame the medical staff for the restrictions, noting:

> *"it's the easiest option to blame the Doctors... 'it's the bloody Doctors that tell us we've got to do all this'"* (SR9)

Of particular interest in this example is how earlier in his interview this particular respondent had spoken about the need for honesty with patients, commenting:

"but I genuinely think we've got a very honest relationship with the patients I think we all try to be very straight with them... I will always say to people whether it's good or bad news, I'll be honest with people." (SR9)

It would appear that on occasion, therefore, it may be easier for some staff to deflect conflict than to try and diffuse it; an apparent reaction to the level of perceived threat and intimidation experienced. However, as in the example above, this deflection may not always be expressed for the benefit of the patient, but may act as a self protecting mechanism. It appeared on this occasion that the staff did not recognise the difference between his stated values of honesty and his behaviour of dishonesty.

This desire to avoid conflict can also take the form of appeasement on occasion; particularly with patients whom the respondents consider to present a significant physical threat when undertaking the special observations. This can take the form of blurring of boundaries, fragmentation of adherence to treatment plans, and a general appeasement of patients as evidenced in the following example of a patient who would often present as intimidating whilst on special observations and who would challenge staff:

"it got to the point where we were just buckling and we were just saying okay; more often than not we were starting to say okay." (SR4)

Of note, however, is that this only appears to be the case for those patients considered by staff to present a significant physical risk. The data suggested that patients who were not considered such a physical threat would often have stricter boundaries placed upon movement and afforded less tolerance in behaviour or challenging of authority. One respondent noted

"it was easy with xxxxxx, he didn't really frighten us, we always thought we could manage him, so it was easy to keep boundaried with him; you know? keep things tight" (SR5)

Respondents spoke of how such appeasement was often considered a weakness and gave rise to criticism from colleagues who would find such actions as a sign of weakening authority and control. One respondent spoke of how

colleagues had criticised him following the use of special observations, commenting

> *"I knew they didn't like it. They thought I was soft, but you know what Des, it worked didn't it. He never hit anyone, so it was them who were wrong wasn't it"* (SR3)

This example highlights how some staff who would adopt a more flexible approach to managing special observations did not always see themselves as appeasing patients. Indeed at times they considered their actions therapeutic; actually criticising their colleagues who would rigidly apply boundaries and limits. It would appear therefore that an appeasing or flexible approach would attract criticism from both those who were rigid in their application of special observations and also from those who were more flexible. What was evident, however, was that the degree of criticism appeared to increase as the perceived risk increased.

In addition to this appeasement, respondents spoke of active attempts by staff to avoid physical interactions with patients whom they considered a potential risk. This avoidance was characterised by encouraging patients to spend time alone in their rooms; allowing disengagement and prevention of potential conflict:

> *"I was quite relieved when he didn't come out, because then you have a conflict situation haven't you."* (SR8)

and also by some staff keeping what they perceive to be a safe distance from the patient if they were unable to be physically removed from having to undertake the observations:

> *"I got a punch anyway (laughs). It was psychotic stuff, but I was much more apprehensive after that. Not scared of him, but, I was disinclined to get so close, within punching range [laughs].*" (SR10)

Whilst respondents spoke of how some staff would openly criticise colleagues when they felt physically vulnerable and isolated, as often the case when managing particularly intimidating patients on special observations, the same did not hold true, however, for patients in seclusion, or when faced with patient aggression that would result in the use of seclusion. As previously noted, on such

occasions individual staff would often respond to the concerns of colleagues by acting in the manner expected of them by their peer group.

This defensive mechanism appears to protect the member of self from scrutiny or criticism by colleagues or the organisation and relieves pressures and prevents conflicts with their peers. By maintaining the support and validation of colleagues, levels of anxiety are reduced and nursing staff can feel socially supported. It is only when concerns for validation and acceptance are over-ridden by concerns for personal safety that relationships with colleagues appear to take on a secondary significance.

A significant behavioural response to the threats presented by patients constantly illustrated in the staff narratives was the concept of patients having to 'progress' if a seclusion episode was to be terminated. The narratives indicated this would often be an identified process to be worked through rather than an individual decision based upon identifiable and observable clinical criterion. One respondent spoke of how a plan with one patient in seclusion involved progressive periods of assessment in different areas of the ward and how time spent out of the locked seclusion room for assessment was actually guided by the patient's physical size and presence:

> *"We would then progress [the patient] into the corridor and eventually down into the night station. From the night station we started off with an hour, which I personally thought was too much initially. I thought 15 minutes was enough given his size and the way he presents."* (SR9)

Other respondents spoke of 'progressing' patients through seclusion, demonstrating that such progress could at times be as dependent upon external factors such as time, control of the environment, or the nature of clinical interventions as it is about the actual mental state or behaviour of the patient himself. One respondent gave an example of how the plan for one patient in seclusion had eventually 'progressed' to the point of having extended assessment periods out of the locked seclusion room, from 9am to 9pm:

> *"I'm thinking more to when we progressed xxx to being on a 9-9"* (SR6)

These examples illustrate how at times patients in seclusion would have to move through a series of stages. These could be geographical in nature, by progressing through areas of the ward, or temporal in nature by extending periods of assessment out of the locked seclusion room before consideration is given to terminating the seclusion episode.

It was evident from the narratives that for some patients secluded within the high dependency areas, there would not be a simple termination of the episode once mental state or behaviour returned to pre-seclusion states. On occasion with some patients there would be a planned, often staged programme developed and worked through before seclusion would be considered. The data suggested that this was not for all patients, but does closely relate to the earlier noted concept of patients often having to demonstrate a greater level of compliance when in seclusion for this to be terminated.

It has been demonstrated, therefore, that threats and pressures in the respondent's environments and working lives lead to specific responses. These responses provide protection from the anxiety and stress arising from interpersonal conflicts, external pressures upon practice, and socially driven commitments to conform to expected behaviours. They serve to provide real time protections that allow for continued functioning and to remain effective in undertaking their role. The data indicates that these responses can be cognitive, emotional, or behavioural in nature, and are adopted with the primary aim of personal survival rather than any attempt at advancing any therapeutically based care or treatment.

The narratives also illustrated how at times staff would respond to perceived threats in ways that indicated questionable professionalism. There were clear examples given by respondents that indicated they and their colleagues would at times display behaviours that were self serving rather than altruistic in nature. This may at times include the use of language or attitudes that appeared dismissive, uncaring and even objectionable and abusive when experiencing extreme pressures and heightened levels of anxieties. The data suggests that at times professionalism can take second place to the open expressions of emotions, concerns, anxieties and fears in response to extreme cognitive, emotional or physical threats to safety, security, functioning and wellbeing.

It has been shown how these responses in the face of direct threat can lead to a disinclination to engage with some patients at times, give rise to an over use of defensive practice, and a leaning towards reliance upon the perceived safety that restrictive practices can provide. There was clear evidence that heightened anxieties can be allayed through disengagement, avoidance of conflict situations and appeasement when physical integrity was considered to be in jeopardy.

3.10 Adapting to stressors / threats

This leads to the final core category underpinning the theory of survival. This relates to the longer term adaptation to the stressors and threats experienced by staff; the protective strategies that enable continuing functioning in the face of pressures, stressors and competing demands in the undertaking of their role. The category relates to how the respondents live with the threats they experience, and, whilst accepting there is a degree of overlap, they differ from the cognitive, emotional and behavioural responses to threats already discussed in that they provide long term protection and are not the short term instinctive responses that staff may well display in specific situations at times of heightened threat.

These adaptations relate more to the generalised changes in attitudes, outlook and behaviour; the mind-set and approach adopted by the respondents to enable continued effectiveness in the role that they perceive to be so stressful at times. They represent the means by which they get through the day and manage to attend for duty day after day following situations of interpersonal conflict with patients; attend for duty the day after they have been threatened or assaulted. These adaptations were categorised as cognitive adaptations and behavioural adaptations and will be discussed in the following sections (see Diagram 19).

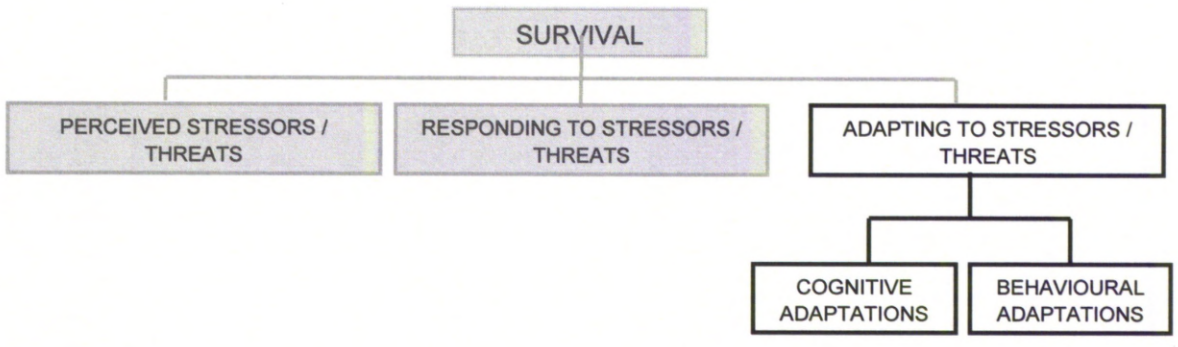


Diagram 19: Sub-categories of adapting to stressors / threats

3.10.1 Cognitive adaptations

These protective mechanisms have several distinct elements that directly relate to the delivery of care and the associated concepts of control, compliance, security and disempowerment. It is in the exploration of these adaptations that it becomes clear how the process of cognitive dissonance plays an integral part in how the respondents protect themselves from stressors and threats. This was evident in many of the staff narratives where they would consistently speak of holding therapeutic and patient centred values, whilst at the same time advocating and supporting alternative practices and actions. This difference between these expressed ideals and behaviour demonstrated a clear dichotomy between articulated belief and action; a difference reconciled through the changing of attitudes and the justifying of one's behaviours. To protect the self from the anxieties associated with the recognition that one's actions do not always hold true to one's internally held beliefs, values and ideals.

Many of the staff respondents demonstrated the ability to protect themselves from potential stress that arose on recognition of conflict and divergence between their values and actions; being able to continue functioning in the face of potential conflict. An example of this can be seen in the relationship between care and control. Respondents would often speak of the importance of providing therapeutic patient centre care, and would articulate the values and ideals of caring health care professionals; with examples including:

> *"certainly within the last 5 years there has been a really accelerated drive for value based care. Certainly in areas that I work in it puts patients at the centre of what we are about and what we do, especially when we are care planning with them and engaging with them."* (SR1)

> *"I am very patient focused now. You have a duty of care in terms of promoting best practice."* (SR4)

> *"some of the best and most caring people I have ever come across have been here at ****. Erm, you know, and that's being honest with you. I think some people do get emotional about things because they care."* (SR3)

> *"I care about patients. I care passionately about them and want to move them on."* (SR2)

"I feel fairly passionate about. or very passionate about, sort of you know? patients being treated with some respect, some dignity." (SR10)

"Because we always try and engage the patients and start talking to people from the moment they are secluded to getting them out, we always show them a bit of, how would you put it, I can't think of the word, its slipped my mind for a minute, a bit of trust and respect and treat them well." (SR6)

In expressing such ideals, however, respondents would also articulate the importance of providing this care within a framework of compliance; the order provided by this compliance appearing important to them and serving as a protector from stress and anxiety. This sense of order provided through routines is often seen as important, with the respondents' appearing to gain a degree of comfort and relief from stress through avoidance of grey areas and avoidance of patient's challenging of authority or decisions. This is particularly significant at times of heightened patient arousal, agitation or hostility when the perception of threats and stressors are often magnified and anxieties heightened.

The protection from stress or threat that such a mindset can provide was evident in the absence of open recognition, appreciation or acknowledgement of the potentially negative aspects of maintaining such a controlling care environment. Respondents would continue to articulate the virtues of therapeutic and forward thinking practice, yet at the same time talk of the importance of patient compliance within this care delivery process. This appeared to provide protection for staff as they were able to reconcile the dissonant feelings between patient centred care and self motivating behaviour by articulating the belief that a controlling care environment is therapeutic and necessary for the good of the patient.

Many of the respondents appeared to disregard the potentially stifling and disempowering nature of the regime they sought at times, and would couch their own insecurities and desire for control in therapeutic terms and by describing benefits to the patient. Evidence of this dissonance can be seen in the examples below in which staff talk of the need for compliance:

"once you get over the control element of the environment you can start looking at care....I think that he needs the structure and the stability around him to maintain a more kind of positive therapeutic engagement." (SR1)

"it was the fact we were looking for a little bit of compliance with the programme. We were trying to get him moved on but, we just wanted a little bit of compliance with his care plan. We can't move him on if he doesn't comply." (SR8)

"at the end of the day it's not to be, you know?, controlling everything; whether someone can watch the TV, whether they can have room access, but feeling controlling in a safe way. I think people felt like we haven't got a handle on this and thus we're not completely safe within it." (SR10)

"he's not doing his plan today, he's not taking his meds, just literally spending a bit of time in his room. And he wouldn't do it, and I think a lot of people found this difficult and started saying no. Not using control as a bad term, as in us controlling xxx, but feeling that we had no control." (SR11)

These examples demonstrate how on the one hand individual staff recognise and profess the virtues of therapeutic progression with patients, yet also advocate and condone the controlling aspects of the clinical environments as having benefits for the patient.

Respondents also highlighted this link between care and control when citing the virtues of negotiation and collaboration with patients. This concept of negotiated care, however, was often found to be contingent upon the maintenance of a power imbalance, control, and the continuing disempowerment of the patient. Examples of how control would be maintained whilst advocating therapeutic and negotiated care included a previously highlighted remark from one respondent when noting:

"we have to work together with this...obviously we're not going to be led by the patient; but we will make appropriate decisions." (SR6)

as well as others commenting:

"by working with them I suppose you are putting some controls in place, and taking it out of their hands. So I suppose it is one I less thing for them to worry about." (SR3)

"I don't feel we'd be doing him any favours because at some point in his life he's going to hear the word no. He can't not work with us on this. It can be said in a controlling manner, but just for his own good." (SR11)

Respondents would often fail to recognise the potentially negative effects of such disempowerment on patient functioning or the care delivery process; again professing the therapeutic benefits to patients of this lack of mutual negotiation. This is seen as a further example of individual staff professing the values of patient centred care whilst actively seeking control, at the expense of true collaboration, because it is considered to be in the patient's best interests.

In a similar vein, respondents would often articulate the value of creativity, changing practice and of embracing new ideas. At the same time, however, they would often talk of valuing the security restrictions, policies and procedures governing their practice. From a cognitive perspective they would often fail to notice the discrepancy between these professed values of advocating a therapeutic milieu whilst also valuing restrictions that have the potential to stifle and disempower. This reliance upon security restrictions, however, appeared to stem from the desire to maintain a safe working environment, with the elements of control and security held as integral factors in maintaining such. Several respondents spoke of how the policies and procedures in the hospital contributed to feelings of safety, noting:

> *"I have worked in other hospitals and it is the safest place I have worked. It has got the most potential and in the papers sounds like a horror story, but the policies and procedures you've got in place and the way you actually work I do feel a lot safer."* (SR10)

> *"I know we can always use seclusion if we need to, the policy gives us that freedom if we feel we are threatened. You always know that is available, you know? In the back of your mind like; in your top pocket so to speak. Gives you a bit of comfort knowing that really."* (SR7).

The staff narratives also illustrated how respondents would often profess the importance of teamwork and collaborative working with peers, yet fail to acknowledge how these relationships with colleagues can impact upon their ability to promote care and wellbeing. Many of the respondents not only failed to recognise the potential adverse affects their relationships with peers may have upon the care process, but also failed to note its potentially collusive nature. The siding with colleagues at the expense of relationships with patients did not appear to cause staff any great concern, with greater anxiety expressed over the fear of

criticism and even ostracism than in potentially damaging a trusting relationship with those for whom they provide care.

This again supported the evidence for dissonance playing part in the protection from threats and stressors. Respondents would justify the close relationships with colleagues as being productive and of benefit to the care process rather than recognising or accepting that the collusive nature of these relationships could actually impact negatively upon the altruistic ideals and values they articulated as being central to their role as care givers. Examples of staff siding together at the expense of, or disregard for therapeutic activity and progress included:

> *"I consider myself a good nurse, but you've got to listen of the concerns of the other staff. You can't just ignore this and be all cavalier. We all have to work together and trust each other or we won't be effective."* (SR11)

> *"And when he is angry and frustrated it's very difficult to say, you know 'come on let's go and get xxx up'. Staff are rightly worried and you don't want to be the one to suggest getting him up when he is like that."* (SR8)

> *"if I am the one to go out on my own and it goes wrong, then I am in the firing line aren't I. I don't mind taking risks but you really have to listen to the concerns of the lads who are with you. We are a team and need to remember that sometimes."* (SR5)

This concern over criticism can itself impact upon decision making at times and lead to questionable motivations in respect of whether decisions are considered as being in the patient's best interests or whether they are influenced by concerns for safety or fear of criticism from colleagues. One respondent spoke of his concern for colleague approval when considering taking patients out of seclusion, commenting:

> *"when I am making a decision, when I am thinking 'come on lets drive this thing forward now', it is there at the back of my mind."* (SR2)

with others demonstrating how at times actions can be self serving at the expense of patient care. Here the motivation to maintain a positive image to colleagues can prove a strong cognitive motivator; serving to protect from the potential criticism and condemnation from peers:

"you know if you go out on a limb they'll criticise you, talk about you behind your back. It makes you think twice about doing something risky because you don't want to piss them off." (SR11)

"You need to rely on your colleagues when it gets iffy, if you can't rely on your colleagues things can get difficult for you, you know?" (SR8)

This concern and seeking of peer approval was a consistent theme throughout the long term adaptations to threats noted by respondents, and clearly outweighed apparent concern for patients at times. Respondents would talk of how following incidents there would be sighs of relief and expressions of mutual support, and yet with no mention or highlighting of concerns for patients. Whilst this in and of itself may not prove disregard for patient welfare, it does serve to highlight how despite professed motivations for progressing patient centred care and supporting the therapeutic process, the concerns for the safety, wellbeing, acceptance and validation for and from colleagues appeared to be of most concern. Examples of such relief and mutual support are evident in the examples below:

"I say a lot of it wasn't just our group. Every group would just sigh, a sigh of relief, which unfortunately meant you knew the next morning it was starting again, but at least you had the relief there and then." (SR9)

"I think when we closed the door everybody kind of breathed out then. I wouldn't say we had a debrief, but we had a brief chat about it. You could feel the relief in the room." (SR3)

"you're anxious all day and you never know what's coming, and you just try and make it through the day. Everyone would go 'ahhh' and just breath a sign of relief because you've made it through the day." (SR7)

A final example of how the staff respondents would protect themselves from the stressors present in their working environments can be seen in their perceptions of patient behaviours. Respondents would consistently recognise patient behaviours as being illness driven and appreciate the crippling effects of their conditions on functioning. However, they would often recount to colleagues previous accounts of incidents involving these same patients; often exaggerating previous behaviours. These exaggerations could make reputations for patients and

at times create monsters in the minds of staff. Examples of this recognition of patient's behaviours being illness driven included:

> *"It is just that head is just so full of voices that you are waiting for your turn to get in, because it's not personalised towards you as an individual, it's against the voices and everything else that's going on in his head."* (SR1)

> *"and xxx listens to her and responds to that, and she had really tried to get into him and say 'look, just go down'. But xxx was so ill that morning he was just telling her to fuck off."* (SR2)

> *"you just think 'well you know he's unwell' and then you get the reassurance from the staff as well, the support of your team, to say 'you know he is unwell and he doesn't mean what he is saying.'"* (SR11)

Yet again, however, respondents failed to appreciate the conflict between their professed perception of patient behaviour and the potentially negative effects on care that could arise from the recounting of tales. These tales would often be recounted as a means of establishing and reinforcing bonds with peers or of emphasising the potentially dangerous aspects of their role. However, they would consistently fail to recognise how the sharing of such past incidents could give rise to reluctance from others to engage with, or progress the care of these patients; some of whom would enter hospital folklore as having the propensity for being 'super' violent and dangerous:

> *"then you run the risk of staff injuries, you run the risk of serious staff injuries. You run the risk of possibly losing control of him and losing half a ward. In the past this guy has smashed an office up, he has electrified the door handles with cable ... if you don't get control of the situation the guy is going to steam-roll out and run amok around the ward really, you know?* (SR1)

> *"I've seen xxx when he was in yyy prison and the change in him is second to none at the moment. When he was in yyy prison he was on a 5 man unlock, erm, he was a known hostage taker and he was a hostage risk to other prisoners in the system. So much so they would literally ring around the whole of the prison and ask for the 5 biggest prison officers."* (SR4)

and from an example given earlier in the chapter:

> "*I think he'd become a monster because, erm, he had been involved in some quite serious assaults on xxx ward and on yyy ward, and then to us. It*

became apparent he was staying with us and I think a lot of the staff I think were of the opinion of he's never getting up this lad, he's never going anywhere. And do you know why he's not going anywhere? Because he's going to kill one of us. When he hits someone he's going to kill someone and we don't want to be here the day that it happens." (SR10)

From this it can be seen that on the one hand the respondents would openly speak of patients in a caring and thoughtful manner, whilst at the same time eliciting fear and concern into the minds of colleagues resulting from their recounting of previous incidents of violence and destruction; fears often elicited without comprehension of the consequences and serving as a means of rationalising the perceived dangers present in their role.

3.10.2 Behavioural adaptations

The behavioural adaptations often adopted by the respondents were firmly centred upon the theme of maintaining control; of ensuring continued professional, cognitive, emotional and physical safety, functioning and wellbeing. They relate to the behaviours integrated into their everyday practice that protect by maintaining a dominant role, and support and reinforce the power imbalance between staff and patient.

In everyday practice these behaviours include the use of practices such as searching, limiting access to patient possessions, restricting movement in areas of the ward, and control of the physical environment. The more potentially invasive practices of physical restraint, seclusion and special observations, however, appear to be used to specifically protect from challenging, unpredictable and aggressive patient behaviours; the behaviours that induce the greatest fear and anxiety. Whilst interventions such as seclusion and physical restraint are only organisationally advocated as a last resort due to their particularly invasive nature, the staff narratives suggested that at times this would not always be the case and that on occasion these approaches may be chosen before exhausting all other options to resolve conflict situations. One respondent noted:

"we know it shouldn't be, we know it is used last, we know the policy, but sometimes you see staff getting that worried and twitchy and maybe they turn the key a bit too soon, you know?" (SR8)

and another commenting:

> *"it's difficult sometimes, when he's in your face and you're thinking 'I am going to get it here', and it is the easiest thing to do, to lock him in. I don't know if that is the right thing to do, but do you wait until he hits you?"* (SR10)

It would appear from the narratives, therefore, that some nursing staff believed seclusion is initiated too soon on occasion; although no respondent indicated that its use was ever undertaken for reasons other than to protect from potential patient violence. What the narratives did suggest, however, is that the individual decision to seclude is not uniform and can be influenced by varying factors dependent upon the individual initiating it.

Respondents would also speak of how on occasion patients subject to seclusion or special observations episodes may not have these terminated as early as they could be; that their use as a protective measure may be used above and beyond that required to provide such a function. There appeared to be three primary reasons for this. Firstly there was the need to appear protective of colleagues, secondly concern over a re-emergence of the behaviours that resulted in the initiation of the initial seclusion or special observation episode, and thirdly the use of 'progressive', staged plans. This could be seen in the staff narratives when noting about special observations

> *"sometimes you just want to air on the side of caution don't you. Its best to be safe than sorry"* (SR12)

> *"there's probably been times when I've let them run when I could have ended them. Its usually when we are on our last early [end of span of duty] and the other group is coming on. Sometimes its best leaving the decision to them as they have to manage it"* (SR9)

Respondents also spoke of how at times following an incident there would often be concern shown for those involved. If the incident had involved an assault upon staff then the decision to terminate the seclusion episode would often take into consideration the concerns of these staff. One respondent in talking of the considerations given to the continuing use of seclusion following one violent incident noted:

"so as an organisation we were being very protective of that group and saying. well before we do anything we need to make sure that group's comfortable with what we are doing, and they're involved in that decision making process. But to the extent that he's not getting up [out of seclusion] and we can't get him up on any other groups because then it will isolate and just make it even worse." (SR4)

In this instance it would appear that continuation or termination of the seclusion episode was as much dependent upon allaying the concerns and fears of one particular group of nursing staff as upon the clinical or behavioural presentation of the patient. Indeed it would indicate that considerations of patient care may have been secondary to some nursing groups concerned for the potential isolation or targeting of another group. Whilst the narratives did not indicate this to be a regular occurrence, it does suggest that at times concern for the feelings of colleagues can override concern for patient feelings or care; again an example of maintaining control and playing things safe. This was seen in the narrative from another respondent who commented on a decision by a care team to continue seclusion with one particular patient:

"so I think that's where people intervened and said we as a Care Team support what happened. We had a big post incident review and discussed it all, yeah it was the right thing to do but erm, but focusing on staff feelings I think instead of patient's feelings. So it's about protecting, feels like protecting the staff because of their fear of what could happen again." (SR7)

This example also provides evidence of the second primary reason why a seclusion episode may last longer than required; the fear of further acting out behaviours. This concern can also be seen in the following example, where another respondent speaks of their concerns about terminating seclusion:

"because fear is a big factor isn't it. As much as we are supposed to be professional people, working within all these guidelines, fear is a big thing isn't it. You are dealing with people who are violent and you get frightened, and maybe people do drag things out slightly, and maybe expect them to be 100% better, but that is never going to happen is it. People are still going to come out suffering from the same illnesses aren't they?" (SR5)

This example suggests not only that seclusion may be extended as a result of fear, but it also speaks of the concept of patients being '100% better'. This was noted by several respondents and was discussed under the category of

'behavioural responses to threats' earlier in the chapter. As well as being a short term response to a particular situation the narratives also suggested that this could also present as a long term adaptation that protected staff from having to deal with challenging behaviour. Patients would enter seclusion as a result of specific behaviours having tipped the balance between what staff would tolerate and what they were not willing to accept. This long term adaptation involves a generalised lowering of the threshold for tolerated behaviours from patients in seclusion and on special observations than those ordinarily allowed. Subsequently patients would be required to display compliant behaviours above and beyond those expected of patients not in seclusion or on special observations. This was highlighted by respondents when commenting:

> *"they have to prove themselves more to get out of seclusion."* (SR2)

> *"They haven't got to be as good as gold, but they do have to prove their behaviour more."* (SR4)

> *"Xxx's behaviour can be the same in seclusion or out of seclusion. But he same behaviour when in seclusion can keep him there."* (SR5)

This notion of patient progress being dependent upon compliant behaviour was further demonstrated in the following example by another respondent, when commenting:

> *"I think you feel sorry for the guy. I think you naturally want to help people when they are in distress, in crisis; and unfortunately until he is willing to take the medication that can relieve him of these symptoms then you know, all we can do is containment."* (SR3)

This example illustrates not only the requirement for the patient to demonstrate compliance, but also places conditions upon 'progress'; namely the taking of medication. Other respondents gave examples of how patient 'progress' would often be dependent upon both compliance and conditional behaviours. One respondent spoke of the need to reaffirm boundaries with one patient before termination of seclusion would be considered:

"erm I think we dealt with it by, bollocking is the wrong word, but certainly we got to the point where, I'd say this as a positive really, but we got to the point where we said 'xxx you're gonna have to do what we ask you to do." (SR9).

In this example termination of seclusion was directly related to compliance rather than clinical presentation, although interestingly when pressed respondents would acknowledge that non-compliance did not necessarily equate to increased risk. One respondent spoke of how non-compliance can be misinterpreted at times and how there may be rationale explanations for such that do not include potential risks to others, commenting:

"like they go he's getting unwell, or he's not right, or he's not doing this, he's doing that. But really if you think about it xxx was probably just pissed off that day, he didn't want to make a collage or something. It doesn't mean he's actually going to punch somebody." (SR4)

It was noted earlier in the chapter how some respondents would place the concerns and feelings of their colleagues above those of patients at times. Whilst this appears to hold true in many situations where the respondents are faced with challenging or threatening patient behaviours, as highlighted earlier, this bond does not hold solid when staff are fearful for their own safety. At times when personal wellbeing is perceived to be threatened, such as when undertaking special observations and when staff feel a lack of immediate physical or professional support from colleagues, self preservation appears to be the dominant behavioural driver. One respondent noting

"I know it sounds a bit selfish, but you know what, I have to look after myself. I don't want to go home hurt and neither does my wife" (SR10)

Similar to the concept discussed under 'emotional responses to threats', this longer term adaptation refers to the behavioural adjustments that respondents employ to counter feelings of fear and personal threat. These largely involve passive responses to dealing with the source of the threat and include aversive decision taking, physical avoidance of patient contact and engagement, and even the passive sabotage of treatment plans on occasion. Evidence from the narratives supporting this aversive risk taking and avoidance of patients included:

Well yes, because we just used to lock them up then until the risk lessened; didn't diminish. There was no kind of formal engagement." (SR1)

"there was an aversion to taking risk management issues forward for fear, or erm, getting some kind of negative feedback on themselves." (SR7)

"We still have some staff who are erm, I think they are frightened, they are frightened. And when people get frightened I think they get tough and perhaps over assess risk more than we should." (SR4)

"You'd get some staff who would use this as an excuse to back off. They would try and get out of getting involved if they could. I think it was fear, you know?" (SR11)

"after the incident with xxx, you would get staff trying to avoid him. You would never see them down the corridor, yeah?.It would be left to the rest of us to deal with him and take the abuse [laughs]." (SR8)

Other respondents commented on how on occasion staff would show a greater reluctance to take risks with patients who had assaulted nurses as opposed to other patients; noting:

"I think staff would be more weary, and less likely to take risks." (SR5)

"I wouldn't say there was a tariff or anything, but you would certainly be more concerned about getting a patient up after he had hit one of us than if he had had a fight with a patient. Does that sound bad? I don't think we do it deliberately." (SR9)

Respondents spoke of how sabotage of treatment plans would take the form of a general reluctance to comply with aspects of patient care plans. This may involve demonstrating reluctance to engage in the planning of care and of undertaking the bare minimum of physical engagement; particularly when on special observations

"I would tend to keep my distance as much as possible. I didn't have to get close to him to watch him" (SR1)

"I've seen some staff deliberately wind up patients on obs by not adhering to the plan. They do it just to get them angry. Get them angry just to prove a point. Where's the professionalism in that?" (SR9)

Other staff noted how colleagues would, on occasion, encourage patients on special observations to remain in their room rather than engage with staff. Such behaviours, whilst not actively damaging progress would potentially hinder the speed with which patients would move forward from seclusion or special observations, and as such would serve to protect by often delaying the re-engagement process or having to face the patient on an interpersonal level without the support and comfort of a restrictive management plan. Examples offered by respondents highlighted this deliberate sabotage of care and included:

> *"I think you would find staff would be trying to sabotage it, and it wouldn't be happening."* (SR3)

> *"there was people who I genuinely think went out of their way to make my life difficult, I felt there was people actively trying to sabotage things that I was trying to do."* (SR10)

3.11 Summary

This part of the chapter has highlighted the findings arising from the staff narratives. It has explored their experiences, attitudes, and beliefs held with respect to the use of seclusion and special observations. It has demonstrated that despite holding altruistic values and a genuine desire to assist patients in achieving health and wellbeing, at times of heightened anxiety and stress, these altruistic values do not always get applied in practice.

The data suggested that nursing staff perceive their working environment to be fraught with danger and risks, and that they subsequently respond and adapt to protect themselves from these. Whilst attempting to forward patient care and maintain their professionalism, they appear to be susceptible to extreme pressures and stress that can at times give rise to approaches that may ultimately prove counter-productive or even anti-therapeutic.

The narratives highlighted how despite feeling genuine concern for patient welfare and the desire to see patients move through the high secure system, they were often flooded with competing and conflicting demands and pressures that clouded decision making and behavioural motivations. It would appear that at times

when fearful and anxious their values and ideals would take second place and that they resort to basic protective cognitions and behaviours; with self preservation proving the ultimate defensive driver. Indeed the motivations for many staff cognitions and behaviours were themselves rationalised through the process of cognitive dissonance; a process that allows staff to protect themselves from thoughts and actions that may conflict with their intrinsically held beliefs. Even on those occasions where nursing staff recognise this dissonance between what is articulated and what is acted upon they will either fail to appreciate the potentially negative affects upon patient care, or will deflect such behaviours onto colleagues and away from themselves.

Integral to this drive for self protection from perceived threats are the concepts of control and compliance. These are seen as integral to the care process; a clinical necessity, and yet the respondents noted that staff will often fail to appreciate the potentially adverse affects upon patient progress. They appear to value their relationships with peers above those with patients and will support colleagues at times of shared risk through the maintenance of a strong unifying bond; a bond that soon appears to fragment, however, when these shared risks turn to targeted threats, and where the perception of physical danger outweighs the benefits of mutual support.

These tensions between the humanistic values of care and compassion, and the self preserving survival strategies so often displayed were rarely consciously recognised or resolved by the staff participants. Whilst these principles were often explicitly stated and illustrated, staff respondents consistently failed to provide evidence that acknowledged or recognised how their behavioural and attitudinal approaches could have such negative effects upon the patients for whom they were professing such philanthropic values and ideals.

The findings highlighted how this dissonance appeared to be contextually linked to the relational culture existing within the staff group. Staff respondents demonstrated a strong need to feel part of a cohesive and supportive group; to conform to colleague and organisational expectations, with this need only fragmenting when personal safety or wellbeing became a primary driver. It would appear that this process of dissonance serves as a protective factor for staff in

resolving, or certainly muting the effects of the tensions and conflicts arising from the perceived need to side with colleagues at times, often at the expense of promoting patient care.

As highlighted, the evidence from the staff narratives indicated that many of the staff failed to consciously recognise this dissonance, and therefore presenting challenges on how to resolve such conflicts in the interests of patient care.

It is noted, from personal researcher experience of the research site, that formal clinical supervision of nursing staff was poorly adopted and embraced at the time the interviews were undertaken with the staff respondents. From this, it could be argued that this brings into question the opportunities for staff to professionally reflect upon their behaviours, values and attitudes towards patients; either in a group or on an individual level, and may well have been a contributory factor in the prevalence and maintenance of such dissonance highlighted in the narratives.

A lack of organisational drive to embrace and enforce such supervision or reflective practice could be seen as stifling change and a contributory factor to the prevailing attitudes and behaviours of staff. Removing the cultural barriers that appear to be contributing to the maintenance of such a situation will prove challenging for the high secure services.

Finally, the concept of 'progression' appeared central to the behavioural responses and adaptations adopted by respondents. The notion that on occasion patients are required to adhere to a planned, thought through process that may include geographical or temporal restrictions and stages before considerations is given to terminating episodes of seclusion or special observations. This suggests that the decision to terminate such episodes may not always be based purely upon clinical assessment, but on occasion upon the reluctance of individual staff to end such forms of management without working through prolonged set patterns of practice that seem to be based in defensive practice; of protecting by keeping things safe.

CHAPTER 4 – DISCUSSION

Discussion

4.1 Chapter structure

The study has explored staff and patient experiences of seclusion and special observations as planned interventions in the management of violence and aggression in one particular clinical area within a high secure psychiatric setting. The study has highlighted the relationship of these interventions to the stressors, anxieties, concerns and threats experienced by both staff and patients in their everyday interactions, and highlighted how the concept of survival can be seen to account for the perception, responses and adaptations to these stressors and threats.

The chapter highlights both similarities and differences in the patient and staff experiences, and compares and contrasts the concept of survival found in these to an established theory of adaptation and survival in institutions; namely that of Goffman (1961). Following from this is a discussion on the different perceptions, views, and opinions on the use of seclusion and special observations between both staff and patient groups.

The chapter then continues with a discussion of study design and potential limitations, followed by consideration of the contribution of the study to the knowledge and understanding of the use of seclusion and special observations within the context of a high secure hospital. Finally there is discussion of the potential implications for future clinical practice.

4.2 The patient and staff experiences

This part of the chapter will discuss the similarities and differences noted in the findings between the patient and staff experiences. It will note relevance to existing literature and compare and contrast the perceptions and experiences of both patient and staff participants. The section will look at both commonalities and differences in perceptions and experiences between staff and patients to demonstrate the different views, opinions and beliefs around power relations, the use of seclusion, special observations, and the general nature of care delivery

within the high secure setting. The discussion will highlight how whilst often holding divergent opinion and perceptions, and experiencing different threats and stressors, the issues and factors influencing these can often be seen to have common basis and context; primarily relating to power dynamics, interpersonal relationships and encounters, and environmental and external issues and concerns.

In discussing these it will become clear how the issues of power, control, coercion, relationships and attitudes are central to the concerns of both parties. It will demonstrate how both prove influential in how patients and staff perceive, interpret and subsequently respond to the stressors identified in their day to day lives, and how the use of seclusion and, to a lesser degree, special observations, can impact upon these perceptions; magnifying the significance for both staff and patients alike.

Analysis of the patient data provided a picture of life within the high dependency areas at the research site. They demonstrated how patients experienced varying stressors and pressures from a variety of sources. The data gave an impression of controlled and disempowered patients who expressed their concerns not just about the use of seclusion or special observations, but also about the care and treatment they were receiving in what they perceived to be a challenging, frustrating, hostile and threatening environment. They spoke of concern over inequality and victimisation, and of their detention in a system they considered to be biased against them.

Specific stressors, antagonisms and threats were identified as relating to care, treatment, seclusion, special observations, and general perceptions of the high secure system and were categorised as relational, interventional and organisational. From the analysis it became clear that both seclusion and special observations were seen as interventional stressors, although their influence and intensity was noted to differ somewhat. Whilst noted to be an interventional stressor in its own right, seclusion was also identified as having the potential to magnify the significance and impact of other relational and institutional stressors. Seclusion appeared to make the normally bearable and tolerable annoyances and antagonisms present within the patients' daily lives as unbearable and threatening

to the point of requiring a protective response. Special observations, however, whilst also an interventional stressor appeared to hold less influence upon the perception of other stressors and were not perceived as such a threat as seclusion.

It was through continued refinement of the data, development of categories, and comparative analysis that the concept of survival subsequently emerged as central to explaining the experiences of patients. It provides an explanatory framework to understand how patients perceive the relational, interventional, and organisational stressors and threats in their environment, and subsequently employ strategies to provide protection to these. It provides an insight into how patients perceive their care and treatment within a controlling, biased and staff centred system that marginalises them, and limits and medicalises attempts at asserting themselves and demonstrating their dissatisfaction. It shows how patients can react to these stressors and threats through responses that, whilst not always productive or self promoting, are inherently self protecting.

Whilst analysis of the staff narratives highlighted how they too perceived stressors and threats in their working lives and how they subsequently adopt protective mechanisms and behaviours to survive these pressures, there were distinct differences in the concerns and antagonisms experienced to that of the patient group. The patient experiences were identified as relational, interventional and institutional concerns and threats; often externally driven events or situations that are imposed and have a direct bearing upon how the patient feels emotionally or cognitively. The staff narratives, however, identified stressors that had a more direct threat to professional, psychological, social or physical functioning. This is to say that patients appeared more concerned and threatened by events that may impact negatively upon aspects of daily living; the here and now, whereas staff appeared more concerned with situations or events that had the potential to prevent continued functioning in their role; more long term consequences.

The following sections discuss the elements and issues within the high secure environment that presented as specific stressors and threats to the staff and patient groups, highlighting the commonalities and differences in experience, perception and opinion.

4.2.1 Seclusion and special observations

This study of seclusion and special observations within a high secure setting has provided the opportunity to explore aspects of current practice of two particularly emotive and controversial approaches to the planned management of violence and aggression within a highly structured clinical environment that has itself been subject to rigorous inspection, examination and criticism in recent years.

The study has demonstrated the intrinsic link between the practices of seclusion and special observations within a high secure clinical setting. It has shown how there is often with a degree of overlap between the two, and how at the research site they are the interventions of choice for both the staff and organisation in the management of challenging and potentially violent behaviours.

This link between both practices was readily illustrated in noting how patients in seclusion are often placed on special observations during times of assessment outside of the seclusion room, and placed on special observations on termination of seclusion regimes to provide an enhanced level of support and supervision in the period post confinement.

The study has also shown that with the drive to find alternatives to the use of seclusion, reliance on the use of special observations has increased. This highlights the use of special observations as an emergent intervention in the planned management of violence and aggression. It is an intervention both encouraged and endorsed by the organisation as being less intrusive and restrictive than seclusion. It is noted, however, that this is despite a lack of established evidence regarding efficacy, efficiency, or therapeutic value. Whilst the drive to reduce the use of seclusion has been a formally recognised and organisationally planned initiative at the research site, the emerging use of special observations, as either an adjunct or replacement, has been less formally considered or planned for; a by-product of the seclusion drive rather than a planned outcome.

This emergence of the use of special observations may have significant implications for future practice, however, given the paucity of knowledge about their use or efficacy, the relative lack of governance and monitoring arrangements

when compared with seclusion, and the divergent views and opinions on their use by staff and patients. These divergent views demonstrate marked differences to the perceptions and opinions of staff and patients recorded in the literature, and provide new insights into how both groups view the use of what the literature holds to be a highly coercive, restrictive and invasive practice. Indeed, it was in the perceptions on the use of special observations that the most significant findings of the study were established.

Existing literature on the use of special observations largely finds that staff dislike them as they feel they are restrictive, overbearing, coercive, and damaging to relationships. These are all altruistic apprehensions that demonstrate concerns for the patient's welfare and wellbeing. These are predominantly supported in the literature on the patient views of special observations, in that they also generally find them custodial, coercive, restrictive and inhumane. This highlights an almost convergent opinion on the use of special observations in the sparse literature there is available. In noting this, however, one should remain cognisant of the different reasons for their use in the literature to those studied here.

The findings from this study, however, found significantly different views and opinions on the use of special observations within a high secure forensic setting. Whilst staff respondents in the study also disliked their use, the reasons for this differ greatly from that noted in the literature. In this study staff concerns were not altruistically driven, but based solely on self preservation and fear for personal and professional safety. This is not to say that the staff in the study did not demonstrate or articulate attitudes or values that were not commensurate with care and compassion, but rather that at times of heightened fear and anxiety, their concerns for themselves outweighed those for others.

It was in the examination and exploration of the patient perceptions of special observations, however, that further differences to the existing literature was found. Rather than finding them coercive, degrading, restrictive and inhumane, the patient respondents in this study demonstrated an unexpected degree of acceptability and tolerance to their use. Whilst proving a source of irritation and antagonism at times, this was largely a result of how the intervention was applied in practice rather than by the nature of the intervention itself. The overwhelming

view of the patient respondents was that the use of special observations were generally more acceptable to the use of seclusion; proved less anxiety provoking, less invasive, and has less adverse consequences to their progress through the high secure system.

The study has allowed investigation into the relationship of both practices to the cultural worlds of both staff and patient groups and helped to determine the level to which the controlling, abusive, punitive and disempowering cultures traditionally associated with these hospitals continue to be perceived as such by staff or patients working or residing in them. It has attempted to "access the silenced voices of the keepers and the kept" in the "often secret and sinister world of the prison and special hospital" (Richman & Mercer, 2002, p77).

It has allowed the patient respondents an opportunity to describe and express their perceptions and experiences, and to offer opinion on care and treatment associated with the management of violence and aggression. These are views and opinions that are often overlooked and rarely considered (Duxbury, 2002) within a clinical setting in which patient views about their treatment often carry little weight (Adshead, 2000). It has also allowed the staff respondents to offer their opinion and views on the hostile environment in which they work. The study has demonstrated how both staff and patient groups live and work within the systems, structures, and cultural world of a high secure system, and highlighted how both groups attempt to survive the stressors and threats experienced within this environment; noting the role of seclusion and special observations as particular and significant challenges and threats

The study findings have shown the divergent perspectives held by both staff and patient groups on the nature of both seclusion and special observations, specifically highlighting therapeutic value, power relations, invasiveness, abuse, punishment, standards and approaches to care and stigma, as particular issues, concerns and threats. Yet whilst many of the expressed views and experiences were found to be consistent with those found in the literature, some have demonstrated a degree of insight into these practices above and beyond that already known in such a specialised clinical environment. The following section will draw together the themes evident in the narratives specifically around the use of

these two interventions, highlighting the differences in views and opinion expressed by the two participant groups. This will assist not only in our understanding of the relationship between the two interventions as held by each group, but also in highlighting the different views of each individual intervention by each.

It was clear from the findings of both the patient and staff accounts that seclusion appeared to be the intervention that generated the greatest amount of narrative. This is not to say that both groups felt this intervention to be more important or significant than special observations; indeed from the staff perspective observations certainly appeared more anxiety provoking than seclusion. However, seclusion certainly generated more discussion and appeared to be the intervention of focus for both staff and patient. This was perhaps a result of its higher profile and controversial nature, or perhaps simply a result of researcher bias. This potential issue of bias will be discussed further in the section on the limitations to the study. Whatever, the reason, the primary focus of the study findings appeared to be seclusion, despite evidence from the narratives from both groups that both interventions were intrinsically linked.

From a patient perspective the findings demonstrated how despite attempts by the high secure services to change culture, modernise services, and improve standards of care and practice, there remained a clear perception of seclusion as being punitive and open to abuse. Several patients highlighted benefits to some aspects of seclusion in that it provided an opportunity to disengage from the therapeutic process, to escape the pressures of the ward, or allowed time to reflect. However, the general perception and experience was that of a harmful, negative and coercive intervention that was practiced within an over controlling and abusive care system. This being a system they perceived as favouring staff, marginalising patients, and in which subservience and compliance were both expected and demanded. These perceptions are all characteristic of the total institutions noted by Goffman (1961) and consistent with the observations of Mason & Chandley (1998, p89) when noting that "it is expected that compulsorily detained patients will be controlled, psychiatrically, behaviourally or physically, and it is expected that the staff will be employed as agents of this. For control to be effected, power is required."

The findings from the patient narratives clearly demonstrated how they viewed seclusion as controlling, disempowering, discriminatory and punitive in its use. They recognised the effects upon care, treatment and progress through the high secure system, and found its use not only to be to be a cause of concern, but also as a threat and stressor that impacted upon their day to day activities and physical, psychological and social functioning. Many of the negative views and opinions regarding the patient experience of seclusion mirror those found in the literature as highlighted in Chapter 1. However, there were some specific elements relating to the use of seclusion that appeared directly related to the culture of the high secure system. These are discussed in more detail later in the chapter when considering elements of high secure care, the relating of survival to existing theory, the issue of temporality, and when considering implications for future practice.

The staff perceptions of seclusion differed significantly from those of the patient participants, and provided insight into the relationship between the controlling elements of this intervention to the staff considerations for the need to maintain compliance and control. The staff participants indicated that whilst the incident or event leading to the use of seclusion may prove anxiety provoking and threatening, the actual management of a patient during a seclusion episode was not always seen as an extreme threat or stressor. The data suggested that the physical barrier of the locked seclusion room often provided physical and psychological protection; the ability to physically withdraw and psychologically disengage. This would last at least until such time as interventions were required for staff to enter the room and interact with the patient without these protections. Whilst patients often held seclusion to be coercive and overused, staff participants often failed to recognise or accept its coercive nature or even acknowledge the potential negative effects upon patients or their relationships with them. Seclusion was often seen as a necessary intervention, and whilst it clearly provided an element of control and security to staff at times of intense anxiety and stress, there was a lack of conscious recognition of this in the staff narratives. Whilst seclusion would often serve as a protective strategy as well as potential stressor for staff in its implementation, the physical and psychological protections were often couched in therapeutic language that focuses upon the welfare of the patient or the ward community rather than the realisation or admission that often seclusion would be self protective rather than patient orientated.

It was not only in the overtly controlling elements of seclusion that a dichotomy of views between patients and staff were found. These divergent perceptions also held true in the narratives regarding the use of special observations, although interestingly with an inverted negativity attributed to their use by patients and staff when compared with the use of seclusion.

Further divergent thought and opinion was noted between groups with respect to the use of special observations. Whilst the patient narratives clearly indicated that concerns generated were rarely to the degree engendered with the use of seclusion, they continued to represent a source of anxiety and stress in their every day lives. These concerns, however, were often more dependent upon the way in which the intervention was undertaken and explained to them than by the intervention itself; only causing heightened concern and anxiety as levels of nursing staff assigned to the observations increased or when their implementation severely impeded or restricted their social interactions and activities.

Whilst the literature on the use of special observations for the management of violence and aggression has been noted to be sparse, particularly within high secure or other forensic clinical settings, there were some findings from this study that were consistent with the general body of knowledge around the use of special observations within mental health settings. This was evident around the poor communication around special observations noted by both staff and patient respondents, mirroring the findings of Fletcher (1999), who found that staff did not always inform patients of the reasons for increased observations.

Of particular interest in the findings was the view that the use of special observations to manage potential violence and aggression was of particular concern to staff; more so than the use of seclusion. Integral to this was the potential for interpersonal conflict, fear of personal safety, and concerns over professional criticism. The significance of this is discussed further later in the chapter when considering implications for future practice. This importance and relevance of these perceptions can be appreciated when considering that 80% of health authorities are using increased observations as a means of managing potential patient violence (Bowers et al, 2000), despite evidence that would

suggest high levels of observation can prove intrusive and counter-productive, and that nurses find it stressful and patients dislike it (Bowers & Park, 2001).

Whilst the findings from this study mirrored some of the evidence from the literature, in that special observations proved stressful for nurses, there were other views, opinions and experiences that did not. Examples of this include the importance of establishing therapeutic relationships with patients when undertaking special observations (Mackay et al, 2005; Vrale & Steen, 2005) and the safety of the patient being the staff's priority (CRAG, 2002; Mackay et al, 2005). In contrast, however, the findings from this study clearly demonstrated that physical, cognitive, social and professional self-preservation was the primary concern of the staff participants, and that aspects of clinical progression or wellbeing were secondary. Indeed, the evidence from the patient narratives suggested that the staff assigned to observations would often disengage from interactions with them; observing from a distance. This was supported to a degree by the evidence from the staff narratives which noted reluctance at times to engage with patients they perceived to be confrontational and challenging. Staff talked of often maintaining what they perceived to be a safe distance from the patient when assigned to special observations to protect themselves from physical threat; this in turn reinforcing a sense of disengagement between staff and patient.

This failure to engage therapeutically whilst undertaking special observations is acknowledged in the literature on observations for the management of self harm (Rooney, 2009). However, whilst Rooney (2009) noted the ethical difficulties that can exist on occasion with the provision of support to patients at a time when choice and self determination can be compromised, this did not appear to be significant in this study. Staff did not appear to experience anxiety or concern about patient choice or of the restrictions imposed except when these appeared to hold influence upon the potential for conflict and the subsequent potential to impact upon their own self-preservation. As with the use of seclusion, it would appear that staff concerns in the use of special observations were born more out of desire for survival than any altruistic or benevolent motivation. This is not to say that both altruism and the need for survival cannot or do not co-exist at times, however the staff narratives clearly indicate that at times of heightened anxiety and extreme pressure the maintenance of one's own physical, psychological and social integrity

and wellbeing clearly prevail. These findings are contrary to those of Lind et al (2004), however, who found that at times staff can struggle with the ethical dilemma of using coercive measures; further noting that the concepts of control and help can often prove inter-related.

Similarly, several staff respondents noted how on occasion special observations were not always driven by patient clinical need. This issue can be seen as similar to the findings of Buchanan-Barker & Barker (2005) who argued that observations policies are used at times to simply reassure managers that action was being taken; providing staff and organisational protection. It was certainly noted in the patient narratives at times that they considered the use of special observations to be organisationally led rather than based on any identifiable clinical need.

4.2.2 Interpersonal relationships and conflict encounters

This section discusses the issues of interpersonal relationships and conflict encounters; issues held important by both staff and patient groups. It was evident from the patient narratives that the nature of their relationships with staff could prove significant in how they viewed issues of power, control and coercion, and how they were seen as proving influential in determining both nature and severity of threat. The findings showed that whilst patient perceptions of their relationships with staff varied at times, the general perception was negative, with trusting relationships being transient at best and subject to deterioration at times of heightened conflict. Patients often talked about staff with a degree of ambivalence, and at the other extreme, as being antagonistic, adversarial, and over-controlling.

Perceptions of staff approaches as controlling were not unique to this study. Duxbury (2002) found that such perceptions could lead to patients perceiving themselves as victims within the context of a restrictive environment. This appeared to hold true for many of the respondents in this study who expressed concerns of victimisation, of feeling discriminated against, and of feeling powerless and helpless. This was particularly evident with the use of seclusion which they readily held to be a punitive, over controlling and unregulated practice designed to control and change behaviour, implemented indiscriminately, and without consideration for less restrictive alternatives. These perceptions were consistent

with the feelings expressed by patients within the literature, which includes the belief of seclusion as being controlling and punitive, used too often, seen as a means of reinforcing the power imbalance, and giving rise to feelings of neglect, vulnerability, anger, frustration, fear, sadness and humiliation (Martinez et al, 1999; Hoekstra et al, 2004; Holmes et al, 2004; Meehan et al, 2004; El-Badri & Mellsop, 2008).

Evidence from the narratives also supports findings from the literature in that when faced with the dilemma of protecting a patient's interests or maintaining the safety of others, including themselves; staff would maintain the safety of others (Kontio et al, 2010). Where the findings from this study differ somewhat from this literature, however, is in the expressed motivations for staff around this use of seclusion. Kontio et al (2010) found that staff would state that the patients best interests were paramount, citing principles of health care and human rights as influential factors in the decision making process. The data from this study, however, would suggest that within the highly structured high dependency environments of the high secure hospital studied staff would generally act in their own best interests and in accordance with cultural norms and expected behaviours; behaviours they believed were expected of them from both colleagues and the organisation itself. The exception to this being when staff perceive immediate personal threat, at which point personal survival strategies are employed at the expense of culturally expected behaviour. Irrespective, the findings clearly indicated that patient interests were generally held secondary to those of the individual staff.

The staff appeared to 'play it safe' and it was only on later reflection that moral, ethical or even altruistic factors appeared to be actively considered. Disappointment, regret, frustration and guilt experienced by staff on the implementation of seclusion have been found in other studies (El-Badri & Mellsop, 2008; Roberts et al, 2009), although the staff narratives in this study suggested that such feelings were often only of concern to staff on later reflection and review. The data indicated that staff would often implement seclusion without expressing feelings; almost detaching themselves from potential anxieties and emotions and acting in such a way as was expected of them by their peer group.

This delayed reaction and general adherence to culturally expected behaviour noted in the findings was considered to be a protective strategy employed to minimise stress and anxiety; to enable them to preserve their own physical wellbeing and that of their colleagues, and to maintain their status and reputation within their peer group. To ensure the preservation of the physical and psycho-social self, even at the expense of relationships with patients. This in part echoes the argument of Whittington & Balsamo (1998, p75) who suggested that "many decisions in forensic psychiatry are implicitly or explicitly driven by fear and the need for safety through power", with the argument here being that such fear and desire for safety need not be purely physical, but can in fact include the anxieties arising from professional and psycho-social threats and stressors and the pressures to conform. Mason (1997) even suggested that at times staff's attitude towards the use of seclusion can be determined by the culture and expected practices of the ward itself and that this can even hold influence over official policies and publicly stated organisational ideals and values. This suggests that the pressure to conform to expected norms can prove a significant stressor to staff faced with the decision to seclude, and supports the findings here in which it would appear that at times the decision to use seclusion may be more staff safety focused than therapeutically driven.

Marangos-Frost & Wells (2000) noted the importance of the emotional reactions of staff to face-to-face patient aggression and violence in the decision to use coercive measures, with Whittington & Mason (1995) also highlighting the nurses perception of threat as central to the decision to use seclusion. And whilst it would be naive to dismiss such potential influences in the face of what are often complex and emotionally laden encounters, the findings from this study would suggest that in the main the decisions to use such overtly coercive measures such as seclusion and special observations was driven more from cognitive than emotional motivations; rationality as opposed to instinctive reaction. Whilst fear and anxiety would certainly precipitate the need for a response; a strategy to relieve the anxieties associated with the perceived threat, the staff appeared to cope with this through established methods of managing conflict situations. Emotion, whilst the catalyst for the response, would not appear to be a deciding factor in which coercive measure would be deployed; more often than not these being pre-

determined by the cultural expectations of the staff group and the organisation itself.

The literature on nurse-patient relationships such within forensic environments is sparse; surprising given the significance of interpersonal relationships in the provision of care and the importance for therapeutic engagement in the prevention of violence and conflict. It has been argued that the nurse-patient relationship is as important in forensic settings as elsewhere (Hammer, 2000) and suggested by Martin & Street (2003) that there is no reason why the therapeutic potential of such relationships cannot be realised within forensic settings. Patients, however, perceived their relationships with staff to be transient and often dependent upon the staff's need to side with colleagues. On the other hand, staff would express their belief that in general their relationships were therapeutic, collaborative and patient centred. This may not be surprising, however, with both parties basing their perceptions on past experiences of the care process within the high secure setting and of interpersonal interactions and conflicts. Indeed, Lind et al (2004) note that patients and nurses may not always share the same perceptions about coercive experiences. This would appear to be the case in this study where at times nurses would rationalize their actions as being in the patient's best interest; a point highlighted by Lutzen (1998) when considering the justification for the use of coercive measures in psychiatric practice.

The patient narratives clearly indicated that their views of staff approaches towards them could significantly influence their perceptions of irritants and frustrations in their everyday lives. The ability to cope with these low level antagonisms would often be compounded by what patients perceived as clumsy, unwarranted or unjustified staff approaches in which they considered staff motivations to be either uncaring at best, or sinister and malevolent at worst. Patients would often cite staff as being distant, not in the physical sense, but in their willingness to engage with them and to act in what they perceived to be their best interests.

This is not uncharacteristic of a high secure environment, however, where cultural and organisational norms encourage such social distancing. This is

considered significant when considering the findings of Katz & Kirkland (1990) who noted that violent psychiatric wards were often those characterised by mutual fear and social distancing. However, social interaction within current high secure practice continues to be underpinned by a culture of 'them and us' and of the social distancing and divergence of roles associated with the total institutions cited by Goffman (1961). Indeed the increased restrictions upon security within the U.K. high secure hospitals since the introduction of the safety and security directions (DoH, 1999) have not only encouraged, but also demanded this social distancing. This in itself may impact upon the provision of care and in particular the use of, and need for coercive approaches to managing conflict within these environment. Some authors have noted that clinical settings that restrict choice, decrease opportunities for mutual support, limit private space, and fail to allow for intimate relationships can increase frustration and boredom and lead to an increase in acting-out behaviours (Novaco & Taylor, 2004; Sclafani et al, 2008). These are all characteristic of the clinical areas examined within this study.

Relationships between staff and patients within a high dependency ward of a high secure hospital were seen to be dependent upon and influenced by the social and cultural norms of that environment. The patients' seeking of help, reassurance, guidance and support appeared to be at odds with the role expectations of staff to maintain order, control, compliance and public safety on occasion. Whilst both existed for much of the time, conflicts arising from the nature of the care system and the restrictions and demands imposed by one group over another invariably polarised these relationships at times; with the brittle bonds that allow for the expressions of care, consideration and compassion on occasion broken or strained by the use of coercive and controlling measures. Irrespective of whether these were perceived by patients as evidence of malevolence, or by staff as justified interventions in the patients' own interests, it was clear from the narratives from both patients and staff that the issue of interpersonal relationships plays a significant role in the determination of perceived threat and subsequent coping responses.

4.2.3 Perceptions of high secure care

It was evident from both the patient and staff narratives that there were strong opinions and views on the nature of the care provided by high secure

services, and of the cultural world within its walls. The patient narratives described a system they held to be biased, collusive and disempowering, and in which they were subjected to both subtle and overtly coercive measures and interventions. This included consideration of the use of seclusion as coercive and controlling, although interestingly this was not the universal perception of special observations. What is not clear, however, is whether this perception of special observations would be considered more coercive if the more overt measures such as seclusion or physical restraint were not so prevalent, and whether special observations were only considered more acceptable because of the severe and extreme nature of the alternatives. Perhaps the lesser of the evils?. This may in part go some way to explaining why patients were generally more tolerant and accepting of special observations in contrast to the extreme negative perceptions and views expressed about the use of seclusion.

Chapter 1 highlighted the tensions in high secure care between the ideals of therapeutic care and practices which focused on containment, control and punishment, and how traditional cultures were deeply entwined with penal philosophies (Mason, 1995). Several public inquiries highlighted the plight of patients within the special hospitals throughout the latter part of the last century, often making reference to the restrictive practices and controlling regimes (Boynton, 1980; Ritchie, 1985; Blom-Cooper, 1992; Prins, 1993; Fallon, 1999). These restrictive practices, such as seclusion and special observations, were historically associated with the maintenance of oppressive cultures and in the case of seclusion considered a highly controversial practice that helped proliferate a culture of power and abuse. This was highlighted by Mason & Chandley (1998, p90) who noted that "seclusion not only became admissible, but culturally correct and just. It became essentially part of the cultural constitution, the code of practice, and the totemic law".

The impact of these external investigations into high secure practice cannot be ignored. The effects upon systems, structures, processes, culture, values and ideals have been far reaching, with impact upon individual staff notable. Widespread changes to managerial accountabilities and indeed personnel have helped drive forward the clinical agenda and assisted in changing the public face of these once closed and isolated institutions. Modernisation and integration into the

NHS have further assisted the special hospitals to open their practice to inspection and research, and provided opportunity for external scrutiny of practice and standards.

However, whilst this heightened gaze upon high secure care has provided opportunity for inspection and examination the effects of such upon front-line staff and patients has often been overlooked. Modern high secure services certainly appear more open to allowing the external clinical and academic world to gaze upon its practice, and indeed all have their own dedicated research departments and links with higher educational centres and universities. Yet whilst outsiders are now more welcome to enter these clinical environments, the effects upon, or concerns of, patients or front-line staff in being the objects of scrutiny, inspection and observation has appeared secondary.

The use of reflexive inquiry in this study allowed the researcher to reflect upon the effects of such external inquiry from a personal perspective and to gain awareness into the potential effects of such upon those participants in the study who have lived or worked through them and how their cultural worlds have changed during this time. The researcher himself has worked through two major public inquiries into the care and treatment of patients at the research site (Blom-Cooper, 1992; Fallon, 1999), as had several of the staff participants. Indeed several of the patient participants had experienced life at the hospital during the most recent inquiry (Fallon, 1999).

Whilst the impact upon individuals experiencing life at the hospital both during and in the aftermath of these inquiries will be personal to them, the service response to the pressures and enforced changes resulting from them will have potentially had similar effects. Clearly observable examples of this at the research site include the relaxation and liberalisation of regimes post Blom-Cooper (1992) and the subsequent heightened security and increased restrictions post Fallon (1999). Personal experience of these events not only changed the author's practice, but also helped shape values, ideals and motivations. From being considered thugs and racists in the aftermath of Blom-Cooper (1992), within 7 years the same staff were found to have become complacent, apathetic, and unwilling to challenge patients (Fallon, 1999). At times the author certainly found

himself subject to overwhelming pressure to change practice, whilst at the same time having to deal with often competing and conflicting organisational directives, objectives and system changes. These practices included restrictive interventions such as seclusion and special observations, with these pressures having a direct bearing upon their use. The author personally observed and noted anxieties in some front line staff post Blom-Cooper (1992) about the use of seclusion, with fear of criticism and a lack of support from management often informally cited by these staff as reasons to refrain from its use. At the same time the lack of formal monitoring or either internal or external gaze upon the use of special observations allowed this intervention to become more prevalent in the management of violence and aggression.

Both the staff and patient narratives touched upon elements of the how the high secure system had changed during their time within it. Interestingly, both patient and staff narratives spoke of concerns about increased security restrictions. However, whilst from a staff perspective this tended to focus upon limitations to how they were allowed to practice, from a patient perspective it focused more upon the reduction in liberties and increased restrictions upon areas of their daily living and contact with the outside world. Therefore, whilst both groups expressed concern about the current balance between therapeutic opportunity and security restrictions, there were divergent thoughts and views on how this was applied in practice and of the effects upon individuals. For example, there was a notable absence in the staff narratives of any recognition or acceptance of the negative effects of increased restrictions upon the patient group, with their accounts expressing more concern about effects upon them and their practice as opposed to their patients or their lives.

Commonalities in perceptions about high secure care were evident in the narratives, however. Views and opinions about the hostile nature of the environment were relatively consistent across both groups, with both staff and patients alike recognising and expressing concern about the level of interpersonal conflict present and fears for personal safety. This is consistent with evidence from the literature, with Whittington & Balsamo (1998) highlighting how the forensic setting "remains a tense and sometimes brutal environment for nurse and patient

alike" (p65) and how "violence, and the threat of violence, is a common experience in the working lives of forensic psychiatric nurses" (p65).

The threat of personal violence appeared of major concern to the staff participants in this study, which again is consistent with previous findings. Indeed Marangos-Frost & Wells (2000) noted how the perceptions and emotional reactions of nurses to potential violence can prove influential in their choice of intervention in the face of potential threat. Whittington & Mason (1995, p288) argued that "the level of perceived threat constitutes a major stressor for nursing staff deciding on seclusion" and how "working in an atmosphere of perceived impending attack is at best unhealthy environmentally and at worst severely debilitating" (p289). These potential harmful effects upon staff within these environments are in and of themselves worthy of consideration and examination, with the effects upon staff of having to adopt custodial and coercive interventions in the care and treatment of patients considered an area worthy of further study (Roberts et al, 2009).

It is within this context of what is often perceived as a highly volatile and stressful working and living environment that the value of studying seclusion and special observations within a high secure setting can be appreciated. The contradictory role expectations arising from the competing values of custody, containment, care and compassion, the pressure to reconcile the roles of social control and therapeutic intervention, and of being both gaoler and healer (Caplan, 1993; Mason & Mercer, 1998; Terpstra et al, 2001; Mason, 2002; Larue et al, 2009), can at times be compounded by extended exposure to threat. This can subsequently impact upon the functioning, abilities and attitudes of forensic nurses, with Kent-Wilkinson (1996) suggesting that positive attitudes can be difficult for nurses to maintain in a forensic environment as a result of disdain over offending behaviours. Indeed, Mason & Chandley (1998) argue that positive outlook and attitudes are often associated with the feelings of control in any given situation. It is clear that the role of staff in forensic environments remains challenging.

4.2.4 Power relations

The findings in the study have demonstrated the continuing complexity of power relations that continue to dominate significant areas of practice within this high secure setting, and so readily impact upon both staff and patient groups.

Power relations were found to be inextricably linked to the social, cultural and temporal elements of the high secure system; factors themselves rooted in the institutional structures, processes and cultural norms described by Goffman (1961). This section discusses the issues of power, control and coercion as they were identified in the findings. It will relate them to existing literature and compare current perceptions on care to traditionally held observations on practice within such hospitals.

Both the patient and staff narratives identified specific concerns relating to the concepts of power and control. From the patient's perspective the stressors and threats experienced often reflected their perceived lack of control over both clinical progress, everyday restrictions imposed upon them, and the nature of care in a high secure hospital. These included concerns over the perceived use of coercive practices, feelings of disempowerment, and a sense of futility in asserting oneself in what they considered to be a staff biased system. The patient respondents expressed concern over challenging aspects of their care and treatment, arguing that this was often regarded negatively by staff and at times perceived as aggression rather than assertiveness.

Determining factors in the patients' perception of threat included both the nature of the interpersonal relationships held with staff and the use of seclusion. Seclusion was specifically identified as an antagonism in which the significance and intensity of stressors and threats experienced in their everyday lives would be magnified. The nature of relationships with staff and the practice of seclusion were seen as catalysts in influencing and determining when the tolerable and acceptable became unbearable and objectionable.

The use of coercive practices appeared to be of particular significance and concern to the patients within the study, and yet to a far lesser degree by staff respondents. The findings demonstrated how patients held a general view that nurses impose control over them, and that this control is enforced within a system that not only condones it, but also fails to regulate staff behaviour; a system that values patient compliance as central to its aims. Staff, however, generally appeared less concerned with the coercive nature of their approaches, of the

potential harmful effects upon patients, or even of the potential impact upon their relationships with them.

Indeed it is clear from the narratives of both staff and patients that perceptions of what constitutes a coercive intervention varied; not only between parties however, but even within groups. For example, perceptions of detention within the high secure system varied between patient respondents, with those on civil sections of the Mental Health Act (TSO, 2007) expressing greater concern than those committed from court or transferred via prison. Evidence from the patient narratives suggested this may well relate to perceptions around justification for detention, labelling as offenders, and restrictions not imposed in previous health care settings. In contrast, however, some respondents who had transferred to hospital from prison appeared to be more accepting of these restrictions and of potentially coercive approaches by staff; possibly a result of previous exposure to more overt or harsh practices whilst in prison. This point was noted by McKenna et al (2003) when suggesting that exposure to coercive interventions in prison may lead to them becoming accepted as normal experiences when exposed within a hospital setting, rather than perceived as coercive. Whilst perhaps going some way in explaining some patient perceptions, there was no evidence from the narratives to support this as being a common theme. Rather, the evidence suggested this acceptance was more likely to be a result of a build up of tolerance to such interventions through familiarisation, rather than any change in perception about whether they were coercive or not.

It was not only the overt approaches of staff, such as in the use of seclusion, searching, or physical restraint that appeared of concern to patients, however, with other coercive approaches also identified. They spoke of other approaches, including temporal and behavioural expectations, with clinical progress determined by compliance and staff determined social norms. This inter-relationship between power, control and coercion appeared complicated, with individual perceptions from respondents regarding acceptability often enmeshed in their overall perceptions of care, treatment, and relationships with staff. This appeared to support what Richman & Mercer (2002) note to be the complexities of the power-knowledge relations present in forensic practice.

It has been argued in the literature that at times the use of coercive measures may be necessary in psychiatric practice. Poulsen (1999) has argued that the treatment of the mentally ill through the use of coercive measures is often accepted as necessary at times, particularly when patient insight is lacking and psychopathology severe. Further, Whittington et al (2009, p792) suggest that at times coercive measures, such as seclusion and restraint, may be required to ensure and maintain effective care. Prinsen & van Delden (2009, p72) have even argued that "there remains circumstances wherein coercive measures seem to be the only option to control problem behaviour". These arguments were supported in the staff perceptions of coercive measures in this study. All the staff respondents were supportive of the use of coercive measures, deeming them necessary to maintain control, order and compliance.

In exploring the use of coercive measures, however, it is important to consider motivations and attitudes towards their use. Husum et al (2008) looked at staff attitudes towards coercive measures and highlighted three distinct mind sets and rationales given by staff for their use. The first is what they term 'critical attitude' and relates to those approaches that are recognised as being potentially offensive and antagonistic to patients, and where there is a general desire by staff to reduce their use as they themselves are aware of the negative effects, such as damage to interpersonal relationships. The second rationale is the 'pragmatic attitude', where staff may employ the coercive measures to maintain health, safety and security. Here staff take a more paternalistic view of the measures and belief them to be necessary to maintain an environment in which care can be readily given; a more neutral stance. The third rationale is the 'positive attitude' where coercion is viewed as a treatment intervention and enforced for the patients' own best interests, often at times when patients may lack insight.

Evidence from the staff narratives supported all three of these potential perceptions. Perhaps the least evident, however, was the 'critical attitude', whereby staff may recognise the offensive and potentially antagonistic nature of the intervention. The findings indicated that whilst staff would at times express concern about the use of measures such as seclusion, these were more often considered following a period of reflection rather than as a demonstration of any reluctance to use at the time of implementation. The adoption of a 'pragmatic attitude', however,

appeared to be adopted more often, with many of the respondents appearing emotionally neutral about the use of coercive approaches such as seclusion or special observations. This attitude would appear to be a more protective one to adopt as it allows for the projection of any potential ethical or moral dilemma externally through the perceived need that their actions are necessary to keep others or the organisation safe and secure. This attitude appeared common amongst the staff respondents. 'Positive attitudes' towards coercive measures was also noted within the staff narratives, with the view that their implementation was necessary for the good of the patient. This almost altruistic perception again allows for external projection and avoidance of ethical conflict, protecting them from any potential emotional and cognitive conflict between the roles of care giver and custodian.

The findings in this study clearly demonstrated that perceptions about the use of coercive measures can vary significantly between staff and patients, with subjective opinions, perceptions, and beliefs appearing individually influenced and determined. This supports the view of Ryan & Bowers (2005) when suggesting that perceptions about acceptability of coercive approaches can be susceptible to situational and contextual influences. Of particular note here, however, is the argument of Adshead (2000) who questioned the extent to which patients in coercive settings, such as forensic environments, actually had the ability to consent to interventions and aspects of their treatment given the overwhelming power imbalances present within such settings and the pressures for patients to maintain their subservient position. Perhaps to play the social roles required of them within the total institution (Goffman, 1961) and those determined and expected of the mentally ill by society (Foucault, 1967).

We cannot simply view this dichotomy of power distribution as satisfactory for the staff and oppressive for the patient, however, as the interplay in reality can prove far more fluid and transient. For example, it has been demonstrated how staff can fear for their own physical safety and feel intimidated and frightened at times; somewhat surprising if one considers the traditional view of power and control over patients in such a setting as being omnipresent and inflexible. Indeed, Whittington & Balsamo (1998) view power relations as having a more dynamic component, with the balance switching from patients fearing the approaches and

control of staff and staff fearing the behaviour of patients. They note that when viewed from afar, the nurse within a high secure forensic environment would indeed appear to hold a great deal of power over the patient, yet argue that when engaged in a dyadic conflict situation there can be a temporary inversion of power relations, leading the nurse to attempt to maintain such a "tenuous grip on power" (Whittington & Balsamo, 1998, p66).

It could be argued, therefore, that in what the patient perceives to be such an over controlling and domineering environment, one of the only ways in which the overwhelming power imbalance can be altered, even temporarily, is through interpersonal conflict, aggressive posturing or violent acting- out behaviours; this is despite the often self-defeating nature of such actions. In contrast, the staff narratives highlighted how they would often express relief from anxiety and stress after placing a patient in seclusion; a finding also noted by Roberts et al (2009) and Kontio et al (2010). This relief from stress may serve to reinforce the use of seclusion as a protective strategy for staff and supports the view argued by Rae (1993) when reporting that the custodial culture of a forensic environment could often be influenced by defence strategies employed to protect from stress, fear and anxieties.

This reinforces the shared nature of threat and danger by staff and patients within their encounters with each other. Whilst patients will often attribute these feelings to the approaches of nursing staff, and what they believe to be both a desire and mandate to maintain control, staff will often view such confrontation as patient driven and psychopathological in nature. This is consistent with the literature in which confrontation is often seen as being between "the selfish and irrational patient on the one hand and the rational and altruistic professional on the other" (Whittington & Balsamo, 1998, p68). This is supported in the evidence from this study in which patients would regularly express concern about their lack of voice, their assertiveness being considered as aggression, and the staff account of events held as the only true account.

The patient narratives highlighted the continuing reliance of staff upon control and compliance, of restrictions, victimisation, punishment and abuse. They felt disempowered and subservient to staff, socially distanced in their relationships

with them, and remained acutely aware of the barriers between the two groups. Evidence from the patient accounts demonstrated the perception of over-controlling structures and processes determining and driving the delivery of care, placing pressure on them to conform, and depressing expressions of individuality and assertiveness. The patient narratives painted a picture of life for patients in a high dependency ward to be one of disenfranchise and marginalisation. Patients spoke openly about how clinical progress was determined by the staff, and how the power imbalance was condoned through overt reinforcement of the patient role, lack of voice, expectations to attend for and accept treatments. They indicated a pressure to succumb not only to the more overtly coercive and punitive interventions such as seclusion or restraint, but also to what Lutzen (1998) describes as the more subtle measures such as encouraging, persuading, manipulating, and trading-off.

The introduction to the study highlighted how the high secure hospitals traditionally displayed and paraded their mechanisms of control; their large walls, locked doors, barred windows, staff uniforms and the carrying of keys, and the placement of seclusion and isolation rooms in view of the ward community. These served to reinforce the power imbalances inherent in the physical, environmental, procedural, social and cultural structures and processes of the organisation that were reminiscent of the punitive power described by Foucault (1977). From a patient perspective many of these overt displays of power remain as visible as ever. The walls, doors, locks, barred windows and the carrying of keys remain; as does the practice of seclusion and the detectable signs of its use within the ward. Examples include such things as separate meal trolleys, placing of clothing outside seclusion rooms, white boards indicating the presence or absence of potential security items in the room with the patient, and the constant presence of staff within the seclusion areas of the ward. It is clear from the narratives that the patients remain acutely aware of the 'punitive power' of the organisation (Foucault, 1977) and its wielding of such power through the actions of the staff.

From a staff perspective, however, there appeared to be less formal recognition of the potentially damaging power relations that were of clear concern to patients in their everyday lives. They were able to recognise the power imbalance between themselves and patients, yet failed to appreciate or

acknowledge the negative aspects of such. Indeed, not only did they fail to consider or understand the potential impact and negative aspects of such an imbalance, they actively sought to maintain it through the use of overtly coercive measures; viewing these as necessary components in the provision of care within the high secure setting. Staff even experienced increased levels of anxiety and stress when such control appeared to wane or was considered under threat. Staff failed to demonstrate concern or unease at any of the physical, environmental, procedural or cultural structures or processes that allowed the overt expressions of power and control to dominate the care process, and indeed often considered themselves and the services provided to be both patient centred and progressively focused.

This divergence of thought and opinion about the use of power, control and compliance was not limited to the overt and visible displays of 'punitive power', however. Power can often be exerted in more subtle ways, with influences of staff upon patients such as indiscreet observation (Bradbury-Jones et al, 2007), penalties and rewards (Holmes & Gastaldo, 2002), and at times even special observations (Muir-Cochrane, 1996). These forms of control were also noted by the patient respondents. They specifically highlighted the lack of negotiation, staff determined progress, the setting of unrealistic expectations and the over use of searching. Concern was also expressed over their actions being judged and medicalised, and the restrictions upon telephone and mail communications.

Staff would often express different opinion on the use of such 'disciplinary power' (Foucault, 1977), however, and note the positive elements of such behaviours in the provision of care. For example, staff expressed differing perceptions about negotiation and collaboration in care planning, care reviews, and risk assessments, all noted by Malacrida (2005) as examples of power used to reinforce patient role. They consistently spoke of the importance of collaborative planning and therapeutic engagement with patients, and despite providing evidence where this would at times fall short, remained of the view that their approaches were altruistic and patient centred. These uses of power did not appear to be recognised by staff as a means of maintaining power, control, dominance or compliance, however, but more a means of maintaining what they perceived to be an effective and necessary framework for the provision of care; the

therapeutic milieu. This would appear to support the view of Hamilton & Manias (2007) who question whether the use of surveillance through observations, whilst a means of exercising social control, cannot be considered therapeutic through the promotion of civility and self regulation.

Malacrida (2005) highlighted how avoidance of conflict and compliance with organisational rules could assist patients avoid punishment and stigma, and help progression through the system; thus allowing them to obtain a degree of positive personal power. This could enable them to remain safe and achieve a limited degree of control over their own lives. This was supported in the patient narratives in that they would speak of active coping strategies and responses to perceived threats by playing the system, avoiding violence and using external supports to help them progress through the high secure system. This perception of positive personal power was reflected in several of the respondent narratives who recognised the benefits of avoiding conflict, although it would appear such recognition was often transient and fragile to maintain with patients often resorting to other less positive coping strategies in response to threats and stressors perceived in the immediacy.

4.2.5 The issue of temporality

One further element of life in a high secure hospital that appears to be of particular significance to patients in their opinions and views of the care process, and in the perceptions and experiences of seclusion and special observations, is that of temporality. It is in discussion of this issue that the distinct nature of a high secure hospital, and the use of seclusion and special hospitals within, can perhaps be placed into further context.

The concept of time within a high secure hospital is distinct from many other psychiatric settings (Chandley, 2007). The specific relevance and significance of time to patients within these settings operates at a number of levels, and can be seen as being inextricably linked to perceptions of care, treatment, victimisation, equity, progress, status and esteem. From a patient's perspective issues of temporality can prove both ominous and disturbing; pervading many aspects of daily life. Such issues can include both length of time detained as well as the nature of how time within a high secure setting is structured.

The average length of stay of the patient respondents interviewed in this study was 9.1 years. For the patients this proved both significant and distressing. Patients in the study who were detained under civil sections, and with no recorded offending history, considered this to be punitive and discriminatory; likening it to the criminalisation of the mentally ill and expressing concern over what they perceived to be the removal of civil liberties. Similarly, those respondents who had been transferred to hospital part way through a determinate prison sentence also expressed concern over their continuing detention; fearing it would extend beyond their release date. In essence having their determinate incarceration commuted into indeterminate detention. The uncertainties arising from this continuing, indefinite, detention was seen as an institutional stressor for many of the patients, often making it difficult to maintain motivation and make long term plans.

Further temporal concerns identified by the patient respondents concerns arose from organisational expectations and imposed demands. This was evident in expressed concerns over the provision of annual care planning reviews, annual applications to review tribunals, specialised treatment approaches that can take several years to complete, and time dependent behavioural expectations. Patients often perceived the expectations placed upon them to be unrealistic, barriers to progress, and unnecessary clinical markers.

Of note, however, was not simply the way in which patients experienced concerns over the length of detention, or in the length of time between progress milestones, but also in the way that time becomes conceptualised by patients and integrated into their day to day coping strategies. The findings demonstrated that at times there would be a re-conceptualisation of time from the usual measurement of hours, days, months and years. Patients would often perceive milestones, such as current clinical status and position within individual care pathways, as more important than the number of months or years in the mental health system. This supports the view of Chandley (2007) who noted such a re-conceptualisation in a study at the same research site. At times future planning would be measured by the identification of targets to be met and goals to be achieved, with the traditional structuring of time often appearing meaningless within a system where progress is measured clinically rather than temporally. These clinical markers appeared to be more significant to patients as these are often what stand between their current

detention and release. For some, the indeterminate nature of their detention meant prioritising day-to-day survival over long term planning.

Temporal concerns were further noted in the findings concerning the use of seclusion, with the patient narratives demonstrating significant concern over their indeterminate nature. It was in the duration of seclusion episodes, however, that the greatest temporal concern was noted by the patient respondents, and is held to be indicative of the differences between how seclusion is often practiced within high secure and more generalised psychiatric settings. It was highlighted in Chapter 1 how the literature on the use of seclusion indicated higher mean durations of seclusion episodes in forensic populations than in general psychiatric settings (Lendemeijer & Shortridge-Baggett, 1997; van der Merwe et al, 2009; Keski-Valkama et al, 2010), with the mean duration of episodes at the research site significantly higher than in general and other forensic settings. This highlights a potential for the experiences of those patients confined for such extended periods at the research site to vary qualitatively to some degree from those secluded for significantly less time within other settings. Whilst the cognitive and emotional impact of seclusion may well elicit similar feelings and emotions in patients across settings, there is potential for the adverse psychological effects of prolonged confinement and isolation to be exacerbated in the patient group at the research site where the duration of seclusion episodes appear significantly longer than those in many other psychiatric environments.

4.3 Relating the findings to existing theory

This part of the chapter discusses the findings from the patient and staff experiences with respect to established theory of survival in institutions. It specifically draws upon the work of Goffman (1961) and his observations of life within 'total institutions'. Despite this body of work being over half a century old, the introduction to this study demonstrated how the traditional characteristics of high secure services mirrored closely those described by Goffman (1961). This was particularly evident in the cultural processes, structures and systems that developed within these large hospitals. Here we will discuss the relevance, commonalities and differences found in this study to the behaviours, reactions and adaptations noted of the patient and staff groups by Goffman (1961) himself. It is

through this comparison that we can come to appreciate the degree to which the high secure hospitals continue to present as characteristic of these 'total institutions'.

In his study of 'total institutions' Goffman (1961) spoke of how patients undergo a 'mortification process' whereby self identify and self determination is stripped from them on admission. He describes this process as a means of cleansing the patient from their previous social and cultural roles and preparing them for life in the institution, where social control and change can occur. He noted the role of the patient to be subservient to that of the staff and of different social worlds existing between both groups. He considered this to be reflective of limited social mobility where each kept to their own, and where there was little overlap or coming together. He spoke of both groups being encouraged to maintain social distance and of being suspicious and wary of one another. Patients would consider themselves to be weak and inferior and mistrusting of staff, of whom they would often hold negative opinions and perceptions.

Goffman's (1961) description of life for patients in 'total institutions' emphasised this abandoning of previous social roles and status, noted how staff were perceived as being agents of the organisation, and of how patients felt excluded from the care process. He highlighted how staff would tease, abuse and punish patients, and how depersonalisation gave rise to the patient perception of being just one of a collective many. Goffman (1961) saw these characteristics of a 'total institution' as symbolic of the power imbalance between patients and staff and spoke at length about how the cultural worlds of each group were developed and maintained. He also noted how tensions and stressors arose within each group, how a privilege system was used to maintain order and compliance, and further described the mechanisms each group established to survive these stressors and threats. It is in comparing the data from the patient and staff narratives that both similarities and differences can be seen with the stressors and antagonisms experienced by the participants in this study to those observed by Goffman (1961) himself.

The narratives from the patient participants in this study demonstrated how they would experience relational, interventional and institutional stressors and threats in their everyday lives that were often not dissimilar from elements of the

mortification process and privilege system described by Goffman (1961). These included a culture of them v us, general poor perceptions of staff, feelings of discrimination, feelings of abuse, punishment and surveillance, and poor staff attitudes and behaviour. They considered themselves to be socially isolated in a staff dominated and controlled system where organisational values and ideals were held as more important than individual personal or clinical need.

Patients would often feel that they were excluded from their care and subject to a staff dominated approach to treatment and progress. They expressed significant feelings of powerlessness and a general mistrust of staff. It was noted how any trusting relationships with staff would appear transient at best and distinctly fragile at times of conflict or heightened emotional arousal. This power imbalance mirrors that observed by Goffman (1961) who noted how questioning of authority would often be considered as defiance, held against the patient, and often attributed to illness or disorder.

The findings from this study also highlighted how patients at times feel unable to challenge, criticise, or complain without fear of sanction. There was a distinct feeling of inferiority and subservience in many of the patient narratives and recognition from the patients themselves that there were two distinct social and cultural worlds. There was a distinct feeling of powerlessness in many of the participant's stories; a position noted by Goffman (1961).

In speaking about the mortification process Goffman (1961) specifically highlighted how patients would be stripped of personal possessions, de-personalised, socially isolated, provided with institutional items for daily living, and where they would have their possessions and person searched on a regular basis. He noted how patients' 'economies of action' were limited in that they were required to ask for many of the basic items ordinarily taken for granted in everyday life; such as making hot beverages, making telephone calls, watching TV, or using the toilet. Again, this was very much in evidence in the patient narratives where they would experience stressors in their everyday lives as a result of having to ask for basic items, or having to wait for basic needs to be met; basic items such as pens, phone calls, access to bedrooms, access to social support networks or even members of their car team. The picture painted of life in a high dependency ward was one where patient access to facilities, amenities and personal items were

monitored and restricted and where permission was often required before access was allowed.

In his description of life in 'total institutions' Goffman (1961) also spoke of a process he termed 'looping'. Here a patient's reaction to stressors or antagonisms in his life, whilst perhaps appropriate and normal, would often be construed as defiant and would be subsequently punished. The 'looping' effect arises as the response is punished; therefore creating additional stressors and, in turn, further reactions deemed as defiant. He noted the cyclical nature of such behaviours, reactions and consequences as being a cause of significant anxiety for patients. This process was also noted to some degree in the patient narratives where patients spoke about how their reactions to the restrictions, antagonisms, stressors and threats in their environment would often have to be muted to prevent further sanction or punishment; even if articulated appropriately and without threat or hostility. It was closely related to the perception that the staff view was the only view of importance and that often their reactions to events, or even questioning of staff would be seen negatively, viewed as non-compliance, and potentially held against them as a barrier to progress.

Therefore whilst elements of what Goffman (1961) described as a mortification process were evident in the daily lives of the patient participants; the depersonalisation, regard for institutional norms at the expense of individualisation, and the expectation of compliance and order, it was in the use of seclusion that this appeared most evident.

With the use of seclusion, patients often talked of having their personal possessions, including clothing, removed and substituted for institutional attire, of having to wait for their basic needs to be met, and of feeling socially isolated from their support networks. Patients spoke of staff disengagement, poor attitudes, a lack of fairness, a reluctance to help, a lack of recognition of personal need or identity and of disempowerment. It was at such times that the two distinct social and cultural worlds of the patient and staff groups became most evident and held by the patient group to be most significant.

Whilst similarities with the mortification process appeared to be particularly evident with the use of seclusion, it is noteworthy that the use of special observations failed to elicit the same degree of concern or consideration and

perception as being punitive or open to abuse. Seclusion and other physical interventions such as restraint or enhanced searching were considered invasive, punitive and over-used by the patient participants, and yet the use of special observations appeared to be tolerated despite it often considered a restrictive and custodial intervention (Barker & Cutliffe, 1999). It appeared from the patient narratives that whilst a degree of mortification would be experienced with the use of special observations this did not cause anxieties or stressors to the degree that was evident with the use of seclusion.

It wasn't just in the characteristics of mortification that similarities could be seen to the observations made by Goffman (1961), however. He spoke extensively about how a privilege system operated within the 'total institution' as a means of maintaining control and order. He observed how patients would often be abused and punished and have sanctions applied for behaviours considered unacceptable to the institution. This was based upon a system of rules, rewards and punishments, and provided the patients with formal instruction on acceptable conduct and behaviour and a means of improving aspects of their life through the gaining of rewards and avoidance of punishments. This is not a unique concept in and of itself, with incentives and disincentives present in normal everyday life. However, the degree of control over patients in 'total institutions' allows for the use of rewards and punishments to hold greater importance and can be applied to basic items of daily living, so that their provision or removal can prove significant in the lives of the patient.

One noticeable difference between the findings of Goffman (1961) and the patient narratives however, is in how the actual privilege systems appeared to have operated. Often privilege systems are based on rewards (the receiving of something favourable) and punishment (the application of negative sanction). However, Goffman (1961) noted that in 'total institutions' rewards were often seen as the lack of sanction. In other words the system was structured so that non-compliance would result in a negative sanction, and yet compliance would more often than not simply be rewarded by a lack of further negative sanctions being applied. In effect, rewards were often simply an absence of sanctions.

Evidence from the patient narratives, however, highlighted more of a goal orientated approach to rewards, where behavioural expectations would be

rewarded with tangible improvements to patient lives, be it in the short term through access to items, facilities or amenities at ward level, or by the promise of progress through the high secure system. It is noted, however, that whilst many of the patient participants noted such attempts at goal directed behaviour, they often reported that many such incentives and promised rewards were perceived as unrealistic to achieve.

Goffman (1961) noted how defiance was met with direct and often visible sanction or punishment, and how compliance was sought by staff. This concept of visible punishment was important as it provided constant reminders to patients of the need to behave in ways acceptable to the institution. Elements characteristic of the privilege system would include such things as suspension of access to items or amenities, psychological mistreatment, ridicule, isolation, seclusion, reduced access to health care professionals, transfer to other wards, or the allocation of demeaning or unpopular tasks.

The concepts of abuse and punishment noted by Goffman (1961) as being intrinsically linked to the privilege system were highlighted extensively in the patient narratives; particularly around the use of seclusion. Seclusion was often associated with punishment and the care provided during time spent in seclusion at times generally considered abusive and associated with poor staff attitudes, degrading treatment, threats, goading, isolation and reduced access to health care professionals. The patient narratives highlighted the perception that whilst seclusion was used to punish, and the visible threat used to maintain order, the promise of progress was often used as a bartering aid to gain compliance and co-operation.

The ease at which rewards and privileges can be provided or withheld by staff was noted both by Goffman (1961) and was also highlighted within the patient narratives in this study. Several of the patients spoke of how a request to use the telephone, make a hot beverage, have access to specific ward areas, or even have a pen to write a letter would at times be delayed, ignored, or outright refused. Patients often perceived these as deliberate attempts by staff to be obstructive, to exert control and dominance, or to deliberately anger or annoy. These concepts can be seen to mirror those noted by Goffman (1961) where patients, particularly during the mortification process would be made to feel subservient and submissive

in an attempt at breaking their will and establishing them into a compliant patient role.

With respect to the use of seclusion, the patient narratives suggested that these behaviours by staff were exacerbated at such times and that staff exerted the greatest dominance over patients at the times where they themselves felt in greatest control. This exercising of control by staff was noted by Goffman (1961) to be a particular characteristic of the 'total institution', whereby any member of staff, irrespective of grade or qualification, appeared to have the right to chastise or punish; to control the patient and use the power held over him either positively or negatively. He noted how patients would often consider the 'boss' to be benevolent and the lower grades of staff more malevolent in their approaches, attributing this to the lower grades being responsible for the handing out of punishments and sanctions. Again, these issues were specifically highlighted by a number of patient participants who commented on how nursing staff would attempt to exert control arbitrarily at times, but particularly during the use of seclusion, and also specifically noting how nursing assistants would often be the most antagonistic towards them when applying sanctions, or providing care during periods of seclusion.

Interestingly, whilst Goffman (1961) also observed the negative perception of unqualified staff amongst the patients in his study, as previously noted, this did not always hold true for the patients in this study. Indeed this negative perception of unqualified staff was reversed for the use of special observations, where it was noted by many of the patient participants that the unqualified staff would often present as more supportive and caring than the qualified staff.

Goffman (1961) not only spoke about his observations on how patients were systematically stripped of identity and made to conform by way of a privilege system, however. He also noted the mechanisms by which patients would adapt to hospital life; how they would re-establish personal integrity and status and come to terms with their plight. How they would survive. He noted that the patients would adapt in different ways and may adopt different means of achieving this. He spoke of four main methods being situational withdrawal, intransigence, colonisation and conversion.

Situational withdrawal was noted to include regression and withdrawal from situations, at times consciously undertaken whilst at other times a result of mental

deterioration. This form of adaptation can be seen to some degree in the patient narratives in the use of passive cognitive and emotional responses and psychological depressors. The avoidance of physical confrontation, disengagement from treatment, self isolation, compliance and subservience, resignation and apathy, emotional detachment, and feelings of helplessness and powerless were all noted by the patient participants and can all be considered forms of situational withdrawal.

Goffman (1961) also spoke of how some patients would adapt to their life in hospital by adopting an intransigent line characterised by intentional challenges to the authority of the institution, or refusal to co-operate. Again, there were similar adaptations noted in the patient narratives where they would speak of fighting back against the system through violence, hostility, non-compliance, the making of complaints and other protest behaviours. Of particular note here is the observation made by Goffman (1961) of these behaviours often being transient in nature. This was also observed in the patient narratives, where such active behavioural responses would be interchangeably used with more productive and less negative adaptations.

A third adaptation noted by Goffman (1961) was that of colonisation. Here patients come to terms with life in hospital, some even to the point of not wanting to leave. Patients, whilst inwardly content with their life may still outwardly remonstrate about their plight at times, particularly in front of peers. This concept did not feature significantly in the patient narratives, however. Whilst there was a degree of resignation and apathy noted with some respondents, each appeared to maintain a drive to progress through the system and out of the hospital. Whilst there did not seem to be any evidence of contentment, it is recognised that the patients participating in this study were all from highly structured high dependency wards designed for behavioural containment and symptom stabilisation. Perhaps patients on the lower dependency wards would have displayed a higher degree of colonization.

The final adaptation noted by Goffman (1961) was that of conversion. Here the patient appears to take on board the official view of himself and acts in accordance with the rules of the institution; he becomes the perfect patient, compliant, eager to please, and friendly to the staff. As with colonisation, this

appears to be a more long term adaptation and was not readily observed in the patient narratives in this study. Again, this may well have been through the selection of participants being from high dependency wards where there appeared to be a continued struggle not only internally in the control of symptoms and behaviours, but also externally in their adapting to life in a high secure hospital and the constraints this placed upon them.

In noting a lack of evidence of conversion in the patient narratives, however, a similar process was observed; namely that of playing the game. The similarities arise through the outward behaviours; the avoiding of conflict, the positive use of relationships with staff, the maintaining of self control and the use of external supports. However, these appear to be more goal directed than true conversions. The patients appeared to be playing the system for personal gain and progress rather than being accepting of it and of its view of him.

It has been shown within the study how the pervading cultures of high secure care in U.K. have their roots in the closed and isolated 'total institutions' as described by Goffman (1961), and how many of these features and characteristics remain today. Yet Goffman's description of life in a mental hospital has not been without criticism or challenge. Critics have accused Goffman of exaggeration, dramatization, and stereotyping in his descriptions of mental hospitals (Weinstein, 1982), disregard and lack of recognition of mental illness (Siegler & Osmond, 1971), and questioning of accuracy and generalizability of his 'total institution' model (Weinstein, 1994). Indeed in reading 'Asylums' (Goffman, 1961) one can appreciate such criticism, particularly given its stark portrayal of life within the hospital of study and captivating style of writing.

Further criticisms have focused not only on the concept of a total institution, but also upon both the mortification process and the attitudes of mental patients to hospitalisation. His critics have cited patient survey studies to substantiate their arguments that mental patients do not suffer such processes or adopt such attitudes to the degree noted by Goffman, with further criticisms often aimed at the lack of structured evidence for his conclusions (Weinstein, 1982).

Despite these criticisms, however, 'Asylums' (Goffman, 1961) remains a highly read and cited source in both clinical and academic fields, despite such questioning. Further, whilst one may well cast doubt upon the accuracy and

generalizability of Goffman's descriptions of life in a 1950's U.S. mental hospital to many modern psychiatric settings, what has been shown in this study is how tangible evidence remains to demonstrate how the systems, processes and cultures of a modern high secure forensic psychiatric service continue to display the characteristics of those described by Goffman (1961). This includes the model of a 'total institution', the mortification of patients, and the negative attitude and perceptions of patients to the hospital system and organisation.

Therefore, whilst authors may contest the current value of Goffman's (1961) description of life in a mental hospital in light of modern practice, it has been argued that it retains a theoretical utility (Weinstein, 1994) and is valuable through its humanisation of an often dehumanised group (Mac Suibhne, 2011).

4.4 Study design

This part of the chapter discusses aspects of study design, including methodological approach, possible influences upon findings, and potential limitations.

4.4.1 The researcher's position

In the methodology chapter the concept of reflexivity was introduced, and with it the specific positionality of the researcher in this study. This position was that of an active member of staff at the research site, a manager of both staff and patients, and ultimately that of researcher. This highlighted the challenges faced by the researcher not only in attempting to reassure participants of the value of the research process, but also of reflecting upon his own values, judgements, preconceptions, and experiences both prior to and during the undertaking of the study.

There is clearly potential for any researcher with experience of the subject being studied to bring 'baggage' to that research and ultimately the possibility of analysing and interpreting the data from his own frame of reference. This potential remained at the forefront of the minds of both the researcher and academic supervisors throughout, and was addressed through the constant questioning of,

and reflection upon the data analysis and the interpretations made as themes, categories and relationships were developed.

This process of turning back on oneself and analysing one's own motives, drives, interpretations, and influences constituted a journey in its own right. To consider not only how one was impacting upon the study, but also to open one's mind to the possibility that the story being told was his own and not that of the respondents. It was this process that ensured the development of theory was grounded in the data provided by the respondents and represented the recounting of event and experiences from their own frames of reference.

The potential for preconceived ideas influencing the research process was not the only issue of concern with respect to the undertaking of the study at this site. As a senior manager at the hospital there was the potential to influence, either positively or negatively, the willingness of staff and patients to participate in the study. Despite the researcher being able to recruit sufficient staff and patients to the study to fulfil its requirements, the potential for sample bias remained a possibility. Whilst the chosen method of having participants approach the researcher may have protected against overt coercion or pressure to engage in the study, the motives of participant engagement needed consideration. With the researcher being a senior manager within the hospital there was the potential for respondents to participate either because they wanted to please or gain favour, or in other ways believing they may benefit from participation in the study. Similarly, consideration had to be given to the motives of those not wanting to participate and whether this was because of a reluctance to reveal their private thoughts or practices.

4.4.2 Limitations to the study

This issue of the researcher's position at the research site was considered a potential limitation of the study. As highlighted above, whilst efforts were made to ensure objectivity, participant motivations must be considered. The 'opt-in' approach was adopted to protect against potential bias or coercion, and whilst this appeared successful, the question has to be considered as to whether those who engaged with the study did so without bias or ulterior motive. With findings potentially influenced and determined by the individual value systems of the

participants, these findings may only partially represent the true experiences, views, values and opinions of the staff and patient groups working and residing within these clinical areas.

This is of particular significance given the experiences of some patients, who spoke about punishment and poor staff attitudes. These respondents were critical of staff and their behaviour at times, speaking about deliberate victimisation and inconsistent approaches. However, one has to question whether staff with potentially poor attitudes or behaviours towards patients would have volunteered to engage in a research study with a senior manager. Whilst one could assume that the staff respondents who did volunteer for the study were either confident in their own approach to patient care, confident in the process and its confidentiality, or had a desire to speak about issues of concern to them, one should not automatically discount ulterior motives for participation. Morrison (1990) noted that on occasion nurses may play a role and put on a show; outwardly displaying and professing attitudes and values of care and compassion when required, and yet often presenting as uncaring and inconsiderate when not observed; with macho attitudes and behaviours often culturally condoned yet "hidden behind a screen of professionalism" (Mason & Chandley, 1998, p91)

Irrespective, however, one still has to question whether the respondents that came forward gave honest accounts of their perceptions and experiences. Were they the staff with more positive or progressive attitudes? those who were more willing to speak of their experiences?, or did staff within the areas who did not volunteer to engage fail to do so as a result of their particular values, beliefs or behaviours?, their fear or concerns of senior management?, or a general reluctance to speak of their concerns or engage in research?

The focus of this study was to explore the experiences of two distinct groups to identified interventions that occur within high secure psychiatric care, with the aim to develop a theory that explains these experiences within this specific context. The theory developed was grounded in these specific perceptions and experiences of the participants, who brought with them to the process their own ideals, values, principles, beliefs and pre-conceptions that were in part influenced by other experiences within the environment they work or reside in.

One final potential limitation is evident in the choice of clinical area at the research site. As previously highlighted, the high dependency areas utilise seclusion and special observations to a far greater degree than other areas of the hospital. However, these interventions are still used in part in other areas of the hospital; on other wards that may not have the same cultural or controlling elements that have been seen to be present within the high dependency areas. The study of both interventions within other clinical areas may have generated different perceptions and experiences of both staff and patients to the use of these interventions and subsequently given rise to different findings.

4.5 Implications for practice

This study has highlighted several issues that will have implications for future practice within these clinical areas. A psychiatric ward should promote feelings of calm, safety and security so that therapeutic interventions can assist in returning the individual to a state of cognitive, emotional, social and physical wellbeing. It was clear from the narratives, however, that rather than a place of safety, both patients and staff considered the environment to be hostile and threatening. It was evident that many of the patient respondents considered themselves isolated, disempowered and overly controlled. They noted poor communication with staff, a lack of negotiation and collaboration, inconsistency of approach, and poor staff attitudes as significant factors affecting their clinical progression. There is clearly much work to be done within these clinical areas to help patients perceive these environments as being more therapeutically focused and less disempowering; work that will require a cultural shift away from a security focused philosophy of care to a more patient centred model.

It is noted that since the commencement of the study there have been several initiatives undertaken at the research site to address some of these concerns. The adoption of a recovery model of care has been embraced and promoted that helps focus attention upon negotiation and collaboration between staff and patients, and provides clearer identification of goals to assist in the pathway and journey through high secure care. Further work on patient inclusion has included the formation of a patient forum in which senior managers and patients come together to discuss and act upon issues affecting the patients and their lives within the hospital. The provision of ward community meetings between

the care team and patient groups further enhances this process on a more local and individual level, and patients are now regularly included in policy development and impact assessments. Work has also commenced in collaboration with external stakeholders to improve the physical environments and therapeutic milieu within wards to promote calmer, less obtrusive and invasive clinical areas. Whilst in the early stages of adoption, this process termed 'healthy environments' has already demonstrated evidence of creative collaborative working between staff and patients.

Whilst both initiatives are only in the first stages of implementation they are both promising examples of attempts at reducing the barriers that have created and maintained the 'them v us' power imbalance so readily noted by the patient participants. The greatest challenge for the high secure services in these areas, however, will be in making sure initiatives such as these become grounded and embedded into practice and culture so that they do not represent tokenistic attempts at appeasement or political correctness.

Similarly, staff respondents also spoke of their working environment as being a dangerous and hostile place. This too will has implications for practice, with work required to ensure that staff working within stressful environments remain effective, clinically focused and not prone to undue pressure or burn-out. This may prove challenging, however, and will require commitment from all levels of the hospital. Indeed, Roberts et al (2009) talks of need to study the psychological impact on staff required to adopt a custodial and often coercive approach to care and treatment, particularly in what he notes to be a changing clinical landscape where previously accepted interventions, such as seclusion, are becoming less tolerable.

Indeed, since the commencement of the study there has been a significant internal drive to reduce reliance upon the use of seclusion; a process actually led by the researcher in his managerial role, and based upon some of the core principles of seclusion reduction identified by Huckshorn (2004); notably high visibility of managers and cultural leaders, workforce development through education, and the use of data to inform practice.

This process in and of itself had the potential to increase anxieties resulting from possible staff perceptions of having to relinquish control and being faced with increased hostility or violence from patients. However, a robust communication and education strategy has actually led to increased empowerment and improved confidence of front line staff in managing interpersonal conflict with patients and has enabled a reduction in the use of seclusion without increased incidents or threats of violence. This successful ability to reduce the use of seclusion within a high secure setting without increasing staff perceptions of danger has been noted by Ching et al (2010), who also that there needs to be a need to expand the literature to examine the impact of reduction in seclusion use upon ward culture and staff attitudes. This adds to what Maguire, Young & Martin (2012) note to be a "scant reference to forensic hospitals" in the literature on seclusion reduction.

This potential impact upon ward culture and staff attitude are considered important points to note. Staff respondents generally found the use of seclusion to be favourable to the use of special observations due to the physical and psychological barriers that seclusion provides. With this drive to reduce reliance upon seclusion there was a potential that there would be a greater reliance upon the use of special observations; an intervention considered by the staff respondents to be more anxiety provoking and threatening to their physical and psychological functioning and wellbeing. Therefore, any shift in focus towards the use of special observations over the use of seclusion may well have been met with a degree of resistance, as nurses attempt to maintain established practices and adopt survival strategies. This potential desire to hold on to the use of seclusion did not occur, however, with evidence of staff embracing the changes noted in the increase in nursing staff terminations of seclusion regimes. Prior to the commencement of the drive to reduce seclusion, January 2011, over 80% of seclusion episodes were terminated by a multi-disciplinary team, that met just once a week, rather than by the nurse in charge of the ward.

This collaborative decision making may at times have led to elongated episodes of seclusion, often a result of nursing staff feeling unsure or unwilling to take the decision to terminate seclusion. Implications arising from this centre on the view that seclusion may not have always been used for the shortest possible time. On occasion patients may have experienced restrictions or impositions that were

not reflective of their clinical presentation. This not only raises concerns based upon clinical appropriateness, but also on moral and ethical grounds; whether the use of seclusion was justified and whether it was in the best interests of the individual patient, the staff, the wider community, or the organisation itself.

Since the introduction of the drive to reduce seclusion, however, episodes are now terminated by nursing staff in over 90% of cases out with of the multi-disciplinary team meetings. This would appear to be a significant cultural shift away from seclusion being a multi-disciplinary led intervention, to one in which nursing staff appear to have regained confidence in their own clinical judgement and decision making; to take more ownership of such a high profile and controversial intervention.

With this reduction in the use of seclusion, however, has been the increased reliance upon the use of special observations. This in itself gives rise to implications for future practice as we see a move away from a highly regulated, monitored and reported on intervention (seclusion) to a less controversial, less monitored or scrutinised intervention (special observations). Given the findings from the staff narratives, the survival strategies employed, and the desire to maintain control, the potential for special observations to become more controlling, regimented and invasive should not be ignored. Staff's concerns about the lack of control available to them with the use of special observations, together with a perceived inability to rely as much upon the use of seclusion may give rise to more protective controlling behaviours, either consciously or unconsciously implemented. This in turn may increase the concern of patients who, at present, do not generally perceive special observations to be overly restrictive or invasive, consider them as less stigmatising, and not impacting negatively upon progress.

There needs to be recognition of the potential to increase pressure and stress on staff with any increased exposure to potentially violent and aggressive patients through the use of special observations. The study has shown how the use of this intervention can lead to inconsistencies in practice and adherence to care planning, give rise to the fragmenting of staff bonds and cohesion, allow staff to disengage from patients, and increase levels of stress to staff who often fear for their personal safety. From an organisational perspective there will be the need to

meet this increased reliance upon special observations with strong governance arrangements, and robust supervision and reflective practice systems to support the staff in the undertaking of this stressful role.

Further implications for practice can be seen in the relationship between seclusion and perceptions of clinical progress. Patient and staff respondents held divergent views on the concept of clinical progress and the role of seclusion in this. For patients, seclusion was seen as a significant drawback to progress, with the indeterminate duration of episodes often limiting planning for the future and giving rise to the belief that seclusion would be considered negatively by clinicians determining their progress through the high secure system. Whilst several spoke of opportunities for reflection and respite from the pressures of ward life, the generally held perception was that seclusion held little therapeutic value. Staff perceptions, however, considered seclusion to be a valuable form of protection from the threats and stressors associated within being in close proximity to potentially violent and aggressive patients, with the physical barrier provided by he locked seclusion room offering opportunity for physical and psychological disengagement. Whilst gaining the support of front-line staff to adopt the more anxiety provoking practice of special observations, however, there is the potential for staff to start stigmatising patients subject to increased levels of observations in the same way as those in seclusion have traditionally been. Special observations may become the temporal markers and barriers to clinical progress that seclusion has been traditionally associated with.

Whilst there is the potential for special observations to become more controlling, the potential for greater collaboration, negotiation and therapeutic engagement should not be underestimated. This may well offer opportunities to breakdown some of the controlling and disempowering physical, psychological, and cultural barriers noted between the patient and staff groups. A move from seclusion to special observations may help develop and maintain improved relationships between staff and patients, reduce interpersonal conflicts, and in turn ultimately reduce reliance and dependence upon the use of controlling and coercive interventions that reinforce the differences and power imbalance between both groups.

A final implication for practice can be seen in the duration of seclusion episodes at the research site. Whilst much work has been done to reduce reliance upon the use of seclusion since the commencement of the study, at the research site there remains a small cohort of patients for whom traditional approaches to managing illness and risk have not proved successful. These patients are often confined to single rooms in longer-term segregation for many months, or even years, with minimal contact outside of the confines of this environment, and whilst not the specific focus of this study, the potential physical and psychological effects of such lengthy confinement should not be ignored nor underestimated. The management of this small group of men should not be ignored or marginalised by a service tasked to provide care and treatment in the least restrictive clinical environment.

4.6 Knowledge and understanding

This section distils the findings of this study and highlights its contribution to the knowledge and understanding of the use of seclusion and special observations within the context of a high secure forensic setting. The study has explored from a patient and staff perspective the experiences of two invasive and coercive practices that pervade the daily lives of those living and residing within this high secure setting. It has demonstrated the relationship of both seclusion and special observations to the stressors and threats perceived by patients and staff in what they consider to be a hostile and at times threatening environment, and identified the physical, psychological and behavioural responses adopted as protective measures to ensure survival.

One of the particular strengths of this study has been the noting of the cultural, social and temporal context in which seclusion and special observations are used, and in not viewing these interventions in isolation. Previous qualitative studies have largely focused upon these interventions with respect to implementation, the subsequent feelings of staff or patients about use, or about aspects of care or treatment during the episode. This study, however, has focused upon the challenges, stressors and threats both patients and staff experience in their everyday lives and linked this to their experiences of seclusion and special observations. It has demonstrated the relationships between those stressors that are often considered tolerable and acceptable and those factors influential in

determining when these stressors and threats become intolerable and requiring of a protective response. The two approaches have not been considered in isolation, but have been viewed from the perspective of their influence and impact upon the cognitive, emotional, physical and behavioural functioning and wellbeing of the participants.

This exploration of both seclusion and special observations from the perspectives of the same respondents has enabled relationships in perceptions to be discovered and allowed for different views, opinions and beliefs of the same participant groups to be examined. It has provided opportunity to explore the relationships between both practices, note similarities and distinctions, and has allowed for comparison of practice from both a patient and staff perspective.

The study has highlighted how the study of staff or patient experiences of seclusion has been a poorly researched element of such a high profile intervention (Terpstra et al, 2001; Holmes et al, 2004; Palazzolo, 2004; VanDerNagel et al, 2009; Keski-Valkama et al, 2010). Of those studies which have been conducted, many have used a survey or questionnaire based approach, with differing participant populations, and in differing clinical environments. Whilst surveys and questionnaires are acknowledged as valid tools for research, their use in this study was considered to be potentially limiting given the nature of what was to be explored with the participants. The use of interviews allowed the research to remain respondent led and provided opportunity for perceptions and experiences to be explored in detail. This allowed for the capture of the minutiae and subtleties of the tale being told and ensured that the emergent theory was grounded in the respondent data.

Those studies that did adopt a qualitative approach, for instance in-depth interviewing as a means of data collection (Binder & McCoy, 1983; Meehan et al, 2000; Palazzolo, 2004, Hoekstra et al, 2004), focused on different participant populations within different cultural, social and temporal contexts, and with largely different aims, objectives, and methodological approaches to provide sufficient deviation from this study. For example Meehan et al (2000) looked at opinion and perception rather than in-depth exploration of experiences, and Hoekstra et al (2004) the long-term adjustment and subsequent effects upon relationships

between staff and patients. The use of in-depth interviews in this study has allowed for an exploration of themes without the limitations that a prescriptive question schedule may have imposed. It has allowed for the emergence of theory from the participants perceptions without preconceived influences and provided a rare opportunity for patients and staff within a high secure setting to voice views and opinions on aspects of care, treatment without constraint. It has also allowed for the exploration of practice from the perspectives of both parties; to gain insight into alternative perspectives of the same practice within the same clinical setting.

The findings demonstrated how patient and staff perceptions of care and progress were inextricably linked to the concept of temporality. Earlier in the chapter it was demonstrated how the duration of seclusion episodes at the research site were significantly longer than that found in the literature (Mason, 1995; Lendemeijer & Shortridge-Baggett, 1997; van der Merwe et al, 2009; Keski-Valkama et al, 2010). The findings highlighted how the indeterminate nature of these long episodes of isolation often serve to reinforce patient disempowerment and lack of control over future progress and planning; adding to the perception of progress based upon clinical markers rather than the temporal norms of weeks, months or years. This perception of marking time based on a non-linear framework proved a stressor to patients. The indefinite nature of their detention would make future long term planning difficult and dependent upon factors other than length of times served; with seclusion held as a significant marker in determining current position in their pathway through the high secure system and an intervention that damaged prospects of progressing. Of significance in this perception of time within the high secure hospital, however, was how the same concerns and anxieties were not expressed regarding the use of special observations. There was no evidence in the findings that indicated the duration of special observation episodes to be of particular concern to patients, nor did they appear to hold the same significance as seclusion. Whilst the use of seclusion was clearly seen as a barrier to progress, the use of special observations held little clinical or temporal importance to the respondents. From this, it is argued that patients within this setting structured their perception of progress around non-linear markers. Patients held such issues as movement to other wards, care reviews, risk assessments, review tribunals, and treatment outcomes as issues of importance; above and beyond a concept of temporality based upon duration or length of time detained.

In contrast, however, the findings demonstrated that staff perceptions of progress were closely linked to, and even dependent upon the traditional temporal markers of weeks, months and years. This was particularly evident in the use of seclusion, where decisions to terminate episodes would often be contingent upon patients progressing through a structured, staged programme of increasing exposure and duration within the ward community. These programmes often appeared based upon temporal requirements than clinical assessment, however; serving to allay staff fears and concerns more than ensuring termination of seclusion when clinical presentation would warrant it.

With specific respect to the use of special observations, the researcher's attempt at finding existing literature for their use for the management of violence and aggression was limited, although reassurance was provided by the experience of other researchers who had similar findings. Mackay et al (2005) were unable to find any pre-existing literature on its use, with Whitehead and Mason (2006) noting an absence of published studies on their use within a secure environment. This study therefore contributes to an emerging evidence base on the use of special observations for this clinical reason; moving beyond that established from both staff and patient perspectives.

It is argued that it is in the exploration of special observations that the most significant study findings can be seen, where the patient respondents often found their use as tolerable; even demonstrating an ambivalence to their implementation at times. This contrasts significantly with the existing literature for their use in other settings and for other clinical reasons. Existing literature largely reports the use of special observations as a means of managing potentially suicidal or self-injuring patients, with patient perceptions of their use reported as being highly controlling and invasive, potentially intrusive and distressing (Neilson & Brennan, 2001), and dehumanising and isolating (Bowles et al, 2002). This focus upon the use of special observations for the management of violence and aggression can therefore be seen as adding to the existing body of literature on their use, even if a highly specialised clinical area.

The study has shown how patient participants clearly indicated a preference for the use of special observations as opposed to seclusion, and generally

considered their use to lack the punitive, controlling and coercive elements of seclusion. Whilst at times disliking the intrusion that the use of special observations brought to their daily lives, these were considered to be a more acceptable form of management than the restrictions imposed by either seclusion or physical restraint. This in and of itself has been seen as having potential implications for future clinical practice.

The use of special observations was not without associated antagonisms for the patient participants, however; annoyances and concerns that can also be found in existing literature on the use of observations for self-injuring patients. A lack of communication and information provided by staff was seen as a potential annoyance (Cardell & Pitula, 1999), as was their attitudes and level of engagement (Jones et al, 2000. The potential impact upon daily activities and social networks were noted as being particularly annoying and frustrating. However, the most significant concerns for the patient respondents regarding the use of special observations were the level of observations themselves and the physical proximity of staff. Patient anxieties, concerns and levels of agitation were found to increase as the numbers of staff assigned to observations increased, with the proximity of staff to within earshot or arms length proving particularly annoying and frustrating. Again, this has shown to have potential implications for clinical practice.

It has been demonstrated how the findings from this study found little evidence of patients feeling distressed, isolated, or dehumanised when subject to special observations for the management of their potential violence or aggression; indeed several respondents noted that they were even unaware of the observations assigned to them. This does not support previous evidence in the literature that suggests patients can consider special observations to be over controlling, custodial and degrading in nature (Bowles et al, 2002). The findings in this study supported a patient view that the use of special observations was insignificant to them at best, and annoying at worst. Whilst the literature highlights a lack of privacy as one of the most distressing aspects of special observations (Bowers & Park, 2001), this was not raised as an issue or concern by any of the respondents in this study.

This lack of general concern over the use of special observations, and their potential impact upon privacy, may well stem from the potential that other, far more

coercive, controlling, invasive and punitive interventions may be implemented if required by staff. Further, there may be a degree of familiarisation with their use; a possibility given many of the respondents had experienced multiple episodes during their stay. This would support the view that with experience, patients views of containment measures may become normalised (Veltkamps et al, 2008). Alternatively, it could also be argued that this represents a means of self-regulation of behaviour on the patient's part; tolerating the lesser of two evils. This was possibly through recognition from experience that such regulation of behaviour and compliance will diminish the need for more coercive and intrusive measures being employed; such as the use of seclusion.

This acceptance of special observations could be considered to represent patients exercising a degree of self-control; a result of exposure to a more liberal and benign approach to the management of the mentally ill (special observations) than the more overtly oppressive forms of management (seclusion), where the need for such self control may not exist. This point was highlighted by Stevenson & Cutliffe (2006) when noting that the use of special observations can be considered as a form of panoptic power (Foucault, 1977), from which awareness of being observed can encourage self-regulation of behaviour. The findings from this study certainly indicated that from the patient perspectives, the overt, highly visible controlling spectacle traditionally associated with the use of special observations in the high secure setting have largely been replaced by more subtle forms of control.

Whilst the reasons why the patient respondents found special observations more acceptable to seclusion may well be multifactorial, of particular relevance is the ability of the high secure services to build upon this generalised acceptance of an intervention that is increasingly replacing the use of seclusion. Potential implications of this generalised acceptance and tolerance may ultimately be the maintenance and development of improved therapeutic relationships between patients and staff and a decrease in highly charged emotional confrontations between both groups that may lead to the use of seclusion. It could also be argued that the more tolerable an intervention to the patient group, the less likelihood of aggression or defiance, and an associated decrease in the stressors generated within the staff group assigned to undertake observations of potentially violent and aggressive patients. Organisationally, a priority has to be the promotion of the least

restrictive form of patient management that meets clinical need. The use of special observations has been shown to be a move in this direction, and an intervention with marked benefits to patients from their perspective, even if not empirically tested or proven. For these potential benefits to be realised, however, there needs to be organisational commitment to maintain focus upon culture change, to ensure appropriate staff support systems are secured and developed, and to promote robustness and transparency in its governance arrangements.

The study has provided new insights into how both staff and patients view the use of special observations, and as such provides new knowledge to add to the sparse literature available for their use in the planned management of violence and aggression within forensic settings.

It has been shown how the literature on staff perceptions of special observations indicates that this can be a highly stressful experience (Cleary et al, 1999) with concerns over patient rights to privacy and dignity the cause of much of this anxiety (Bowers & Park, 2001). Highlighted in this study, however, is how the undertaking of special observations can prove of significant concern and anxiety provoking for nurses for reasons significantly different to those cited in the literature. Whilst the literature has highlighted that at times nurses may disengage and withdraw from patients when assigned to special observations, this has largely related to concerns over patient dignity and privacy, and feelings of unease in observing patients at particularly sensitive times; such as when using the bathroom (Duffy, 1995). Evidence from the findings in this study, however, demonstrated whilst nursing staff would also withdraw and disengage at times, this was closely correlated with fear for personal safety. The findings provided no evidence that the staff respondents felt anxiety or unease over the observation of patients at sensitive times, or that they were concerned over issues of privacy or dignity. This evidence of staff withdrawal and disengagement was evident in both the staff and patient narratives and highlighted how at times this disengagement could take the form of physical and/or psychological withdrawal. The findings highlighted how at times staff would place themselves at significant distance from the patient to ensure their continued personal safety, and on those occasions where more than one staff would be assigned to the observations would often focus their attention on interacting with each other rather than the patient.

The lack of concern for the impact of the special observations displayed by staff in this study is not common in the literature, where nursing staff have been found to experience frustration and moral concerns over what they perceived to be the controlling nature of the intervention (Fletcher, 1999). Indeed, in contrast, the findings from this study demonstrate how the staff expressed significant concern and heightened anxieties over the perceived lack of control that special observations afforded them. Without the barrier of a locked seclusion room door many staff feared for their immediate physical safety and would on occasion adopt practices that were neither part of the cultural norm, nor part of agreed care plans. These behaviours included the lying to patients to deflect hostility and anger, and acquiescing to patient requests rather than challenging non-acceptable behaviour. Such behaviours were not noted in the use or management of seclusion, or in the day-to-day interactions with the patients, where the emphasis was clearly upon control, compliance, and adherence to culturally expected behaviours. Evidence here, however, indicates that when faced with direct personal threat staff will at times adjust their behaviour away from what is expected of them and adopt protective strategies to ensure personal survival.

This issue of acting according to expected cultural norms has proved to be a further significant finding with respect to the use of special observations within the context of the high secure setting. The culture in high secure hospitals has been reported in several previous inquiries (Boynton, 1980; Blom-Cooper, 1992; Prins, 1993), highlighting strong affiliations and pressure upon staff to conform to expected cultural norms. Indeed it was even reported in the Blom-Cooper inquiry (1992) that individual staff who spoke out against the larger staff group received death threats, suffered vandalism of cars, and experienced threatening phone calls. Mason has further argued that conforming to expected behaviours and practices within the high secure setting was necessary to gain the support of colleagues and to be accepted as an integral member of the staff group (Mason, 2007).

Whilst the findings from this study found no evidence to suggest that the pressure for staff to remain part of the accepted cultural group continues in any way, shape or form to the degree or intensity noted by Blom-Cooper (1992), the

evidence did support the view of a cohesive, close knit staff group with respect to the undertaking of their daily tasks, and in the use and management of patients in seclusion. At such times staff respondents were often conscious of the need to support colleagues and work to practices accepted by the staff group. Concern was often expressed over potential criticism and ostracism from colleagues and staff would often appear more concerned with how decisions would be viewed by their peers than with the impact of their behaviour upon the provision of care to patients.

The findings on the use of special observations, however, noted significant differences to this close knit cohesive and supportive culture. Evidence from the staff narratives identified how when faced with heightened anxieties for their own personal safety, staff would often become openly critical of colleagues, and would act in what they perceived to be their own best interests rather than in accordance with what others expected of them. This motivation for self-preservation and survival appeared to outweigh the pressures to conform to culturally accepted behaviours and practices. This suggests that the traditional view of culture within a high secure setting, with its foundations based upon strong affiliation and camaraderie, can in fact prove to be brittle. The motivators for physical, psychological, and professional survival appear to outweigh any concerns for social acceptance and endorsement from peers at times of extreme anxiety and threat. This open criticism of colleagues with respect to the use of special observations was seen as a significant shift in attitude and behaviour from that displayed by the staff respondents in other aspects of their role. Even the use of seclusion, with the associated anxieties of having to manage potentially violent patients failed to elicit such a response in staff. It was in the staff experiences of special observations that the concept of personal survival was most evident.

This study has provided a unique insight into the socio-cultural world of nursing staff within a high secure setting. It has gone beyond basic perceptions and views, and exposed the personal and professional fears, anxieties, concerns, conflicts, and dilemmas that affect nurses in the undertaking of their role on a daily basis. It is this exploration and analysis of their world that has provided new understanding of how and why cultural norms are developed and maintained, and

how differences exist between commonly held and collectively shared social and professional bonds and allegiances, and the drivers for individual self preservation.

The study has demonstrated how staff will only remain part of such a cohesive group when considered in their best interests to do so, but that they will break from this at times of self concern. This has provided a valuable insight into how staff view their role; particularly in the provision of special observations. It provides opportunity for organisational change and the provision of enhanced systems for staff support, through improvements to service governance and monitoring arrangements and heightened focus upon supervision and reflective practice.

This study has added to the body of knowledge about forensic psychiatric nursing through appreciation of the stressors, antagonisms and threats experienced in managing challenging behaviour and potentially violent and aggressive patients within a high secure forensic setting. It has highlighted how staff can often view their working environments to be hostile and dangerous, and how the use of restrictive and coercive practices often contributed to this. This was particularly evident when assigned to the role of special observations, and highlighted how despite advocating and articulating altruistic values and ideals, the staff were often behaviourally driven by emotional, psychological, social and physical motivators aimed at self preservation and the maintenance of professional integrity and standing.

It is through the staff narratives that the complexities of the roles expected of the forensic psychiatric nurse have been laid bare. Their stories have illustrated how at times these expectations, be they peer group or organisationally driven or determined, can lead to conflict with the philanthropic ideals and values expected of professional nurses. Whilst previous studies have highlighted the duality of roles between custodian and care giver (Kent-Wilkinson, 1996; Holmes 2002, Gadow, 2003) and how the "values of custody, detention and imprisonment are interposed with those of care, consideration and compassion" (Mason & Mercer, 1998, p2), this study has provided insight into the practicalities of such complexities and dilemmas. It has highlighted this through the reporting of the rich descriptions and analysis of staff stories, opinions, perceptions and experiences.

The study has provided a lens with which to peer into the socio-cultural world of a forensic psychiatric nurse within a high secure setting and allowed external gaze upon what is often a thankless and criticised role; a role often undertaken by caring and compassionate staff with inherent humanistic values and ideals. In this, it has highlighted how despite holding these values as important, the external organisational, clinical and patient related pressures faced on a daily basis within such environments can lead to the articulation and expression of such ideals to take second place to personal and professional survival. This has been shown to be particularly evident in the use of special observations, where the ethos of engagement and support is all to often replaced by supervision, surveillance and distancing.

It is not only in the exploration and examination of the staff cultural world that the study has proved of use. The findings have demonstrated clear divergence in thought and opinion between staff and patient groups regarding not only the use of seclusion and special observations, but also in the perceptions of the nature of care and treatment within a high secure setting. Identification of this dichotomy between how both parties view the nature of their living and working environments, and the stressors, threats and anxieties faced in their day to day lives, helps identify the direction of change required. Meehan et al (2006) have suggested that social and organisational factors need to be addressed to change the punitive subcultures inherent in forensic psychiatric facilities and to ensure a balance between security and effective therapy. Perhaps if such changes can be developed and nurtured, then we may be in a better position to address the concerns noted by Whittington & Balsamo (1998, p65) when questioning how we "can re-humanise the total institution, where so much forensic psychiatric care is still delivered".

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APPENDIX 1

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forensic mental health

THE UNIVERSITY
of LIVERPOOL

PATIENT INFORMATION SHEET (version 1.0)

28th March 2006

Title: "Staff and patient experiences of seclusion and special observations in high secure care"

Researcher: Des Johnson

Invitation:

You are being invited to take part in a research study. This information sheet will explain why the research is being done and what it will involve. Please read the following information carefully and discuss it with others it you wish. If you would like more information then I can be contacted at the address at the end of this document. Thank you for taking the time to read this.

What is the purpose of the study?

The aim of the study is to explore staff and patient experiences of seclusion and special observations in high secure care. I would like to interview patients who have experienced being in seclusion or being placed on special observations. This is to gain a greater understanding of the impact that these interventions have on patients. It will look at feelings, views and opinions on how and why these interventions are used. It will also look at how they have affected you.

Why have I been chosen?

You have been chosen because you have recently been in seclusion or on special observations.

Do I have to take part?

It is up to you to decide whether or not you wish to take part. If you choose not to take part it will not affect your treatment in any way. If you decide to take part you will be free to withdraw from the study at any time. You will not need to give a reason if you wish to

withdraw. The standard of care you receive will not be affected if you decide to withdraw or not to take part.

What will happen next?

You will be given time to consider whether you wish to take part in the study. After a period of at least 24 hours you will be approached by your Ward Manager and asked for your decision. If you decide not to take part in the study you will not be contacted again. If you would like more information then your Ward Manager will contact me on your behalf. I will then arrange to meet with you to discuss the study in more detail. Alternatively, your Ward Manager has a copy of the full research proposal if you would like more information without contacting me directly. If you agree to take part then your Ward Manager will contact me and inform me of this. It is important that your R.M.O. gives consent for you to take part and confirms that they believe you are capable of giving informed consent. I will only approach your R.M.O. once you have indicated that you are willing to take part in the study. If you do agree to take part you will be asked to sign a consent form.

What will my participation involve?

If you agree to take part you will be interviewed. The interview will last approximately one and a half hours and will be audio recorded. You may be asked to undertake a further interview depending upon the issues discussed at the first interview. The interview(s) will explore your thoughts, feelings, views and opinions on the use of seclusion and special observations. This will also include how you feel they affected you. I will also need access to your medical notes. This is because it will be important to examine the official records from the period of seclusion or special observations you have experienced.

The risks and benefits

The study will focus on your experiences, feelings and views about seclusion and special observations. Because recalling thought or feelings about these times may cause you to feel uncomfortable or upset your doctor and primary nurse (ICC) will be given information about the nature of the study. This is so that they can offer you any support you may need. You may withdraw from the study at any time. You will not have to answer any questions or discuss any issues that you find uncomfortable or in any way distressing.

The information obtained from the study will be used to help improve how we practice seclusion and special observation. It will also offer you the opportunity of expressing your views and opinions on these particular aspects of your care and treatment.

What if something goes wrong?

If you wish to complain about any aspect of the way you have been approached or treated during the course of this study you may use the usual NHS complaints procedure.

What happens when the study stops?

When the analysis is completed you will be provided with a copy of the results.

Safety procedures

At the beginning of each interview you will be informed that what you discuss will be confidential. However, if you indicate any current intention to harm yourself or others then a member of your care team will need to be informed.

Confidentiality

The audiotapes from the interviews will be typed and the tapes held securely until the study has been completed. When the study is completed the tapes will be destroyed. There will be nothing written from the interview that might identify you. All information will be coded and stored without your name or address so that you cannot be recognized from it. Any quotes used when the study is written up will be anonymised so that you cannot be identified. Members of your clinical team will not be given access to the audio-tapes or to the written records of the interviews. The only people who will have access to these will be myself and my University supervisors. I will be the only person who will have direct access to your medical records, although the content of these may be discussed with my University supervisors.

Who is organizing and funding the research?

The study is being organized as part of a PhD project at the University of Liverpool and is being sponsored and funded by the NHS National Research and Development Programme on Forensic Mental Health (fmh).

Who has reviewed the study?

The study has been reviewed by an expert panel made up of mental health professionals outside of high secure services. The study has also been reviewed and approved by the Local Research Ethics Committee.

Contacts for further information:

Thank you for taking the time to read this information sheet. For further information about this study please ask your Ward Manager to contact me, or you can write to me directly at the address below.

Des Johnson
Assistant Service Manager

APPENDIX 2

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forensic mental health

THE UNIVERSITY
of LIVERPOOL

STAFF INFORMATION SHEET (version 1.0)

28th March 2006

Title: "Staff and patient experiences of seclusion and special observations in high secure care"

Researcher: Des Johnson

Invitation:

You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others it you wish. If you would like more information then you can contact me at the address at the end of this document. Thank you for taking the time to read this.

What is the purpose of the study?

The aim of the study is to explore staff and patient experiences of seclusion and special observations in high secure care. I would like to interview staff who have recently experienced nursing a patient in seclusion or nursed a patient on special observations. This is to gain a greater understanding of the impact that these interventions have on staff; to explore feelings, perceptions and opinions on how and why they are used and the effects of nursing patients under these conditions can have on staff.

Why have I been chosen?

You have been chosen because you have recently nursed a patient in seclusion or on special observations.

Do I have to take part?

It is up to you to decide whether or not you wish to take part. If you choose not to take part it will not affect your employment in any way. If you do decide to take part you are free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part will not affect your employment.

What will happen next?

You will be given time to consider whether you wish to take part in the study. After a period of at least 24 hours you will be approached again by your Ward Manager and asked for your decision. If you decide not to take part then you will not be approached again. If you would like more information then you can contact me at the address below and I will arrange to meet with you to discuss the study in more detail and answer any questions you may have. Alternatively, your Ward Manager has a copy of the full research proposal if you would like more information without contacting me directly. If you decide to take part then you should contact me at the address below. Participation in the study will require you to sign a consent form.

What will my participation involve?

If you agree to take part you will be interviewed. The interview will last approximately 1 - 1.5 hours and will be audio recorded. A further interview may or may not be required depending upon the issues discussed and the information obtained in the first interview. You will only be asked to undertake a maximum of two interviews. The interview(s) will explore your thoughts, feelings, views and opinions on the use of seclusion and special observations and the impact these have on staff.

Risks and benefits?

The study will focus on your experiences and is primarily interested in your feelings and views about seclusion and special observations. You may, of course withdraw from the study at any time and will not have to answer any questions or discuss any issues that you find uncomfortable or in any way distressing. However, you may utilise your local supervision and staff support systems if required. In terms of benefits, the information obtained from the study will be used to help improve how we practice seclusion and special observations and will offer you the opportunity of expressing your views and opinions on these specific and controversial aspects of high secure care.

What if something goes wrong?

If you have any concerns about any aspect of the way you have been approached during the course of this study you may withdraw your consent at any time

What happens when the study stops?

You will be informed when the analysis is completed and be provided with a copy of the results.

Confidentiality

Once the audiotape from the interview has been transcribed (typed up), the tapes will be securely held until the study has been completed, upon which they will be destroyed. All information will be coded and stored without your name or location so that you cannot be recognized from it. Any quotes used when the study is written up will be completely anonymised so that you cannot be identified. No member of staff within the Trust will be given access to the audio-tapes or to the transcript of the interviews. The only people who will have access to the audio-tapes or the transcripts will be myself and my academic supervisors at the University of Liverpool.

Who is organizing and funding the research?

The study is being organized as part of a PhD project at the University of Liverpool, and is being funded and sponsored by the National Research and Development Programme on Forensic Mental Health (fmh).

Who has reviewed the study?

The study was reviewed by an expert panel made up of mental health professionals external to high secure care. The study has also been reviewed and approved by the Local Research Ethics Committee.

Contacts for further information:

Thank you for taking the time to read this information sheet. For further information about this study please contact:

Des Johnson
Assistant Service Manager

APPENDIX 3

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THE UNIVERSITY
of LIVERPOOL

PATIENT PARTICIPANT INTERVIEW SCHEDULE (Version 1.0)

28th March 2006

"Staff and patient experiences of seclusion and special observations in high secure care"

The following schedule highlights the broad areas to be discussed during the interviews with patient participants. The nature of the interview is to explore patient attitudes, feelings, opinions and experiences. Therefore, the actual questions asked will often be determined by the responses given to preceding questions and, through the process of constant comparison, by data gathered in preceding interviews with other participants. This schedule offers the researcher a framework to work within and allows for the in-depth exploration of the themes arising from the interview without the constraints that a prescriptive question schedule would impose. It is recognised that not all areas will necessarily be explored on each interview or with each respondent; nor explored in any particular order. However the broad areas to be explored include…

1. Introduction

Provides a non-threatening opportunity to set the scene, confirms that the participant is fully aware of what to expect and reaffirms confidentiality and ability to withdraw consent at any time. Will include…

- Introduce study and to self
- Reaffirm confidentiality, voluntary nature, & ability to withdraw at any time
- Reaffirm use of tape recorder and security/disposal of tapes
- Explain and inform about what to expect in the interview
- Reaffirm intention to harm self or others will be reported to the care team

2. Background

Allows for the gathering of basic background and demographic information about the participant. Also offers the participant the opportunity of imparting factual information in own words and time, and help to put at ease. Will include …

- Age
- Ethnicity
- Time in high secure care
- Previous residence / institution / route into high secure care (eg: penal, healthcare)
- Ward placement history within high secure care
- Clinical diagnosis and legal status (eg: section of MHA 1983)

3. Definitions and awareness

Exploration of the participants understanding of the concepts under study. Allows for these to be expressed in their own words and without imposed meanings. Will include …

- Definition of / what does participant understand seclusion to be
- Reasons for use of seclusion
- Definition of / what does participant understand special observations to be
- Reasons for use of special observations
- Definition of / what participant understands high secure care to be
- Reasons why high secure services exist; the role they perform

4. Perceptions of high secure care

Offers the participant the opportunity to impart personal views and opinions on the role of high secure services. Focus on broad general issues rather than explore specific interventions. Will include …

- Perceptions of behaviours warranting placement in high secure care
- Expectations of care within high secure services prior to detention
- Participant's understanding of 'quality'
- Perceptions of family/friends view high secure services
- Participant understanding of public perceptions of high secure care

5. Perceptions on care and treatment within high secure care

Offers the participant the opportunity to impart views and opinions on their own personal care and treatment in high secure care. Focus on broad general issues rather than explore the specific interventions of seclusion or special observations. Will include …

- Compare perceptions of current experiences to prior expectations
- Perception of their need to be in high secure care
- Opinion and views on current ward placement
- Perception of how others view their level of dangerousness
- Perception of relationship with staff (eg: benevolent v malevolent, caring v uncaring, interested v uninterested, controlling v empowering)

6. Experiences of seclusion (commencement)

Offers the participant the opportunity to impart their personal views, feelings and opinions on their own experiences of seclusion; specific focus on its implementation. Will include …

- Perceptions of behaviour prior to most recent episode of seclusion
- Description and exploration of incident that gave rise to seclusion episode
- Perceptions of the reasons why seclusion was initiated
- Perception and understanding of own behaviour &mental state at time
- View of the legitimacy of the use of seclusion in own case (were staff right to use seclusion at this time? has this view changed since the incident itself ?)
- Perceptions and opinions of alternative approaches that they feel could or should have been utilised
- Perceptions of the seclusion episode as a negotiated intervention (explore level of involvement and collaboration in care between patient and staff)
- Perception of the initiation of the seclusion regime and how it was conducted (eg: explore issues of dignity, control, power, resignation, frustration, anger, relief, expectations)

7. Experiences of seclusion (during)

Offers the participant the opportunity to impart their personal views, feelings and opinions of their own experiences of their time in seclusion. Will include …

- Explore activities available during period of seclusion; get participant to describe how time was spent
- Participant to reflect upon restrictions upon daily life and activities and explore associated feelings, frustrations and coping strategies in undertaking practical daily functions
- Understanding of personal 'wants' and 'externally prescribed needs'
- Perception of negotiation and collaboration during the seclusion episode
- Perception of empowerment and choice during the seclusion episode
- Perception of staff attitudes during episode of seclusion (eg: helpful v unhelpful, informative v secretive, approachable v distant etc)
- Current feelings of legitimacy of seclusion and whether this view changed during time secluded
- Participant to give opinion on positive and negative aspects of the seclusion experience (let them use their own words and attribute their own meanings)
- How participant spent 'free thinking time' in seclusion (eg: focus on personal issues or concerns? External issues or concerns?)
- Elicit suggestions from participant on changes to current practice that they feel would have proved beneficial to them during their time in seclusion
- Explore relationships with peer group during time in seclusion
- Opinion on seclusion environment and suggestions for improvement

8. Experiences of seclusion (post)

Offer the participant the opportunity to impart their personal views, feelings and opinions of their own experiences of seclusion, with specific focus on its termination. Will include …

- Feelings and concerns rejoining peer group and ward community
- Perception on termination of seclusion regime (timely? negotiated? explicitly stated expectations?)
- Perceived changes by peer group in approach towards participant
- Participant to reflect back on experience as a whole (positive v negative)

- Explore experience of seclusion with respect to modifying behaviour to minimise further seclusion episodes

9. Experiences of special observations (implementation)

Offer the participant the opportunity to impart their personal views, feelings and opinions on their own experiences of special observations with specific focus on its implementation. Will include ...

- Perceptions of their behaviour prior to their most recent episode of special observations (setting the scene)
- Description & exploration of incident that gave rise to observations
- Perceptions of the reasons why special observations were initiated
- Perception & understanding of own behaviour and mental state at time
- View of the legitimacy of the use of special observations in own case (were staff right to use special observations at this time? has this view changed since the incident itself?)
- Perceptions and opinions of alternative approaches that they feel could or should have been utilised
- Perceptions of the special observation episode as a negotiated intervention (explore level of involvement and collaboration in care between patient and clinical team)
- Perception of the initiation of the special observations regime and how it was conducted (eg: explore issues of dignity, control, power, resignation, frustration, anger, relief, expectations etc)

10. Experiences of special observations (during)

Offer the participant the opportunity to impart their personal views, feelings and opinions of their own experiences of their time on special observations. Will include ...

- Explore activities available to the participant during period of special observations; get participant to describe how time was spent
- Participant to reflect upon restrictions upon daily life and activities and explore associated feelings, frustrations and coping strategies in undertaking practical daily functions
- Understanding of personal 'wants' and 'externally prescribed needs'
- Perception of negotiation & collaboration during the special observations episode
- Perception of empowerment & choice during the special observations episode
- Perception of staff attitudes during episode of special observations (eg: helpful v unhelpful, informative v secretive, approachable v distant etc)
- Participant to reflect upon current feelings of legitimacy of special observations and whether this view changed during time on special observations
- Participant to give opinion on positive and negative aspects of the special observations experience (let them use their own words and attribute their own meanings)
- Explore how participant spent 'free thinking time' whilst on special observations (eg: focus on personal issues or concerns? external issues or concerns ?)
- Elicit suggestions from participant on changes to current practice that they feel would have proved beneficial to them during their time on special observations
- Explore relationships with peer group during time on special observations

11. Eperiences of special observations (post)

Offer the participant the opportunity to impart their personal views, feelings and opinions of their own experiences of special observation, with specific focus on its termination. Will include ...

- Feelings and concerns rejoining peer group and ward community
- Perception on termination of special observations (timely? negotiated? explicitly stated expectations?)
- Perceived changes by peer group in approach towards participant
- Participant to reflect back on experience as a whole (positive v negative)
- Explore experience of special observations with respect to modifying behaviour to minimise further episodes

12. Care, control, coercion, compliance, surveillance and punishment

Explores the participant's perceptions, views and beliefs about the use of seclusion and special observations from the perspectives of care, control, coercion, compliance, surveillance and punishment. Will include ...

- Exploration of participant perceptions of the benevolence or malevolence of high secure care
- Understanding of constructs of 'patient centred care' and 'empowerment' and their relevance/relationship to seclusion and special observations
- Understanding of constructs of 'negotiated care' and 'prescribed care' and their relevance/relationship to seclusion and special observations
- Understanding and opinion of seclusion and special observations as therapeutic interventions.
- Constructs of 'fairness' in the use of seclusion and special observations (eg: similar behaviours by different patients resulting in different interventions being used)
- Views on 'tariffs' for specific behaviours (eg: longer in seclusion for assaulting staff)
- Perception & experience of seclusion/special observations being clinically focused or sanction/punishment for non-compliance or rule breaking
- Explore the construct of coercion with respect to direct or implied threats of seclusion or special observations in response to specific behaviours (eg: use for social control)
- Perception of seclusion and special observations as a response to patient behaviour or perceived level of dangerousness

APPENDIX 4

fmh
forensic mental health

THE UNIVERSITY
of LIVERPOOL

STAFF PARTICIPANT INTERVIEW SCHEDULE (Version 1.0)

28th March 2006

"Staff and patient experiences of seclusion and special observations in high secure care"

The following schedule highlights the broad areas to be discussed during the interview with staff participants. The nature of the interview is to explore staff attitudes, feelings, opinions and experiences and therefore the actual questions asked will often be determined by the responses given to preceding questions. This schedule offers the researcher a systematic framework to work within and allows for the in-depth exploration of the themes arising from the interview without the constraints that a prescriptive question schedule would impose. In recognising the length of this schedule it is noted that not all areas will necessarily be explored on each interview or with each respondent. However the broad areas to be explored are...

1. Introduction

Provides a non-threatening opportunity to set the scene, confirms that the participant is fully aware of what to expect and reaffirms confidentiality and ability to withdraw consent at any time. Will include...

- Introduction to the study and to self
- Reaffirm confidentiality, voluntary nature, & ability to withdraw at any time
- Reaffirm use of tape recorder and security/disposal of tapes
- Explain and inform about what to expect in the interview

2. Background

Allows for the gathering of basic background and demographic information about the participant. Also offers the participant the opportunity of imparting factual information in own words and time and help to put at ease. Will include ...

- Age
- Ethnicity
- Time employed in high secure care
- Previous employment
- Ward placement history within high secure care
- Explore qualifications and experience of forensic mental health nursing

3. Definitions and awareness

Explores the participants understanding of the concepts under study and allows for these to be expressed in their own words and without imposed meanings. Will include …

- Definition of / what does participant understand seclusion to be
- Reasons for use of seclusion
- Definition of / what does participant understand special observations to be
- Reasons for use of special observations
- Definition of / what participant understands high secure care to be
- Reasons why high secure services exist; the role they perform

4. Perceptions of high secure care

Offers the participant the opportunity to impart personal views and opinions on the role of high secure services. This section will focus on broad general issues rather than explore specific interventions. Will include …

- Perceptions of behaviours that should warrant/justify placement in high secure care
- Expectations of care within high secure services prior to employment
- Perceptions of care within high secure services since commencing employment
- Participant understanding of 'quality'
- Participant understanding of the wider perceptions of high secure care (eg: media/public etc)

5. Perceptions on care and treatment within high secure care

Offers the participant the opportunity to impart views and opinions on their own personal experiences of providing care and treatment in high secure care. This section will focus on broad general issues rather than explore the specific interventions of seclusion or special observations. Will include …

- Compare perceptions of their actual experiences in comparison to expectations prior to employment within high secure services
- Perception of the need of the patients he/she nurses to be in high secure care and opinion and views on current area (ward) of work
- Perception of their relationship with patients (eg: benevolent v malevolent, caring v uncaring, interested v uninterested, controlling v empowering)

6. Experiences of nursing a patient in seclusion (commencement)

Offers the participant the opportunity to impart their personal views, feelings and opinions on their own experiences of nursing a patient in seclusion, with specific focus on its implementation. Will include ...

- Description & exploration of a recent incident that gave rise to seclusion episode
- Perceptions of the behaviour of the patient prior to this episode
- Participant perceptions of the reasons why seclusion was initiated
- Perception and understanding of the behaviour and mental state of the patient at time of incident
- View of the legitimacy of the use of seclusion in this case (were staff right to use seclusion at this time? has view changed since the incident itself?)
- Perceptions and opinions of alternative approaches that they feel could or should have been utilised
- Perceptions of the seclusion episode as a negotiated intervention (explore level of involvement and collaboration in care between patient and staff)
- Perception of the initiation of the seclusion regime and how it was conducted (eg: explore issues of patient dignity, control, power, frustration, anger, fear, relief, etc)

7. Experiences of nursing a patient in seclusion (during)

Offers the participant the opportunity to impart their personal views, feelings and opinions on their own experiences of nursing a patient in seclusion, with specific focus on nursing care during the episode. Will include ...

- Explore how participant spent time; explain and describe care provided (eg: conversing, supervising, supporting, reassuring, directing, etc)
- Explore feelings about same (boredom, fear, anxiety, frustration, anger, hostility, etc)
- Perception of own role in providing care to patient in seclusion (benevolent, caring, controlling, boundary setting etc)
- Perception of negotiation and collaboration with the patient during the seclusion episode
- Perception of patient empowerment and choice during the seclusion episode
- Perception of patient attitude and behaviour during episode of seclusion (eg: compliant v non-compliant, angry, agitated, hostile, approachable, dismissive etc)
- Reflect upon current feelings of legitimacy of seclusion in this case and whether this view changed during time nursing the patient
- Participant to give opinion on positive and negative aspects of the experience of nursing patient in seclusion (let them use their own words and attribute their own meanings)
- Explore how participant spent 'free thinking time' whilst nursing a patient in seclusion (eg: focus on professional or personal issues or concerns? ability to relax, concerns for own safety, etc)
- Understanding of pressures and challenges in providing care to a patient in seclusion – explore participant coping strategies for same
- Elicit suggestions from participant on changes to current practice that they feel would have proved beneficial to them in providing care to a patient in seclusion
- Participant opinion on seclusion environment and suggestions for improvement

8. Experiences of nursing a patient in seclusion (termination)

Offers the participant the opportunity to impart their personal views, feelings and opinions on their own experiences of nursing a patient in seclusion, with specific focus on nursing care during the episode. Will include ...

- Participant feelings and concerns about patient rejoining peer group and ward community
- Perception on termination of seclusion regime (timely? negotiated? explicitly stated expectations?)
- Perceived changes by staff group in approach towards participant following termination of seclusion
- Offer opportunity for participant to reflect back on experience as a whole (positive v negative)
- Perceptions of positive or negative effects of seclusion in helping to modify or change patient behaviour

9. Experiences of special observations (initiation)

Offers the participant the opportunity to impart their personal views, feelings and opinions on their own experiences of nursing a patient on special observations with specific focus on its implementation. Will include ...

- Description and exploration of an incident that gave rise to an episode of a patient being placed on special observations
- Perceptions of patient behaviour or mental state prior to the episode (setting the scene)
- Perceptions of the reasons why special observations were initiated
- View of the legitimacy of the use of special observations in this case (were staff right to use special observations at this time? has this view changed since the incident itself ?)
- Perceptions and opinions of alternative approaches that they feel could or should have been utilised
- Perceptions of the special observation episode as a negotiated intervention (explore level of involvement and collaboration in care between patient and staff)
- Perception of the initiation of the special observations regime and how it was conducted (eg: explore issues of dignity, control, power, frustration, anger, fear, relief, etc)

10. Experiences of special observations (during)

Offers the participant the opportunity to impart their personal views, feelings and opinions of their own experiences of their time nursing a patient on special observations. Will include ...

- Explore activities available to the participant during period they nursed the patient on special observations; get participant to describe how time was spent
- Reflect upon the restrictions placed upon the daily life and activities of the patient and explore perceptions of how these may have affected patient
- Participant's feelings, frustrations, concerns and coping strategies in nursing a patient on special observations
- Understanding of difference between patient 'wants' and prescribed patient 'needs'
- Perception of negotiation and collaboration during the special observations episode
- Perception of patient empowerment and choice during the special observations episode
- Perception of patient attitude and behaviour during episode of special observations (eg: compliant v non-compliant, angry v friendly, trustworthy v duplicitous, willingness to engage v distant etc)
- Opinion on positive and negative aspects of nursing a patient on special observations (let them use own words and attribute own meanings)

- Explore how participant spent 'free thinking time' whilst on special observations (eg: focus on current role and work related tasks? external issues or concerns? other?)
- Elicit suggestions from participant on changes to current practice that they feel would have proved beneficial to them, or to the patient, during the episode of special observations
- Perceptions of the relationship between patient and peer group during time on special observations

11. Experiences of special observations (termination)

Offers the participant the opportunity to impart their personal views, feelings and opinions of their own experiences of nursing a patient on special observation, with specific focus on its termination. Will include ...

- Feelings about patient rejoining peer group and ward community
- Perception on termination of special observations (timely? negotiated? explicitly stated expectations?)
- Explore whether the participant perceived any changes by self or others within staff group in approach towards patient
- Offer opportunity for participant to reflect back on special observations nursing experience as a whole (positive v negative; explore reasons for same)

12. Care, control, coercion, compliance, surveillance and punishment

Explores the participant's perceptions, views and beliefs about the use of seclusion and special observations from the perspectives of care, control, coercion, compliance, surveillance and punishment. Will include ...

- Exploration of participant perceptions of the benevolence or malevolence of high secure care
- Understanding of constructs of 'patient centred care' and 'empowerment' and their relevance/relationship to seclusion and special observations
- Understanding of constructs of 'negotiated care' and 'prescribed care' and their relevance/relationship to seclusion and special observations
- Understanding and opinion of seclusion and special observations as therapeutic interventions.
- Constructs of 'fairness' in the use of seclusion and special observations (eg: similar behaviours by different patients resulting in different interventions being used)
- Views on 'tariffs' for specific behaviours (eg: longer in seclusion for assaulting staff)
- Perception and experience of seclusion/special observations being clinically focused or sanction/punishment for non-compliance or rule breaking
- Construct of coercion with respect to direct or implied threats of seclusion or special observations in response to specific behaviours (eg: use for social control)
- Perception of seclusion and special observations as a response to patient behaviour or perceived level of dangerousness
- Perceived importance of patient compliance in determining need for seclusion or special observations

APPENDIX 5

Research Governance Committee
Research & Development Department
Tel: (direct line) XXXXXXXX
Fax: XXXXXXXXXX

Mr D Johnson
Assistant Service Manager

5th July 2006

Dear Des

Project : 2006/13 – Staff and patient experiences of seclusion and special observations in High Secure Care

Following the approval by XXXXXXX (Adult) Local Research Ethics Committee and the XXXXXXXX Research Governance Committee, I am pleased to confirm that your proposed research study within XXXXXXXXX NHS Trust can proceed.

All research conducted in this Trust must comply with the full requirements of the Research Governance Framework for Health and Social Care (www.doh.gov.uk/research) and in full adherence with the submitted project protocol approved by XXXXXXXXX NHS Trust and the relevant Research Ethics Committee.

This letter provides proof that the relevant Trust committees have formally reviewed your project.

A representative from the Research Governance Committee will continue to contact you in the near future to monitor the progress of your research. You will be asked to complete a progress monitoring form *every* ***six months***. Please inform this Department immediately of any proposed changes, amendments to or deviations from the Ethics Committee and Research Governance Committee approved protocol. Also, if it looks like your recruitment period is going to overrun or any part of your research is delayed, please inform the relevant service lead and the Research Governance Committee.

On completion of the research, you will be requested to forward a copy of your final report and complete the relevant feedback and summary information as required by the Trust and the specific directorates involved in hosting your research. In the dissemination of the research, the Trust may request you to present your research study and findings.

Can I also take this opportunity to remind you that, it is the responsibility of the Investigator/s carrying out projects such as this to ensure that any service user that is recruited into a study completes a written consent form and that a copy of the form is kept in that patients **medical notes**. In accordance with Department of Health guidance the Trust will be auditing a random sample of participant's medical notes to ensure that consent forms are present and have been completed correctly.

Best wishes for your research and I look forward to finding out more about its progress and outcomes.

Yours sincerely

XXXXXXXXXXXXX
Research & Development Manager

APPENDIX 6

(Patient) noting brutality on previous ward - getting a kicking
(Patient) rub-down searches giving rise to sexual feelings and thoughts
(Patient) use of long term seclusion on clinical grounds
(Patient) ability to maintain self control despite feelings of intense anger
(Patient) ability to share a laugh with some staff
(Patient) access to fresh air being helpful when in seclusion
(Patient) acknowledging culture of staff always being in the right
(Patient) acting out behaviours in HMP
(Patient) added pressure of heat in seclusion being uncomfortable
(Patient) administered medication making patient drowsy
(Patient) aggressive feelings due to victimisation
(Patient) aggrieved that he was secluded after being assaulted by another patient; who wasn't secluded
(Patient) altercation with staff over removal of personal property whilst in seclusion
(Patient) ambivalence to observations
(Patient) anger at length of time spent in high secure care when considering crimes of others
(Patient) anger at seeing patients with serious offending histories progressing quicker than those without
(Patient) apologising to staff following assault
(Patient) assault on staff for attempting to grab patient
(Patient) assaulting staff due to history of intimidation towards patient
(Patient) authorities not telling the truth
(Patient) aversion to use violence even when provoked or assaulted
(Patient) being discriminated and victimised for wearing dark glasses
(Patient) being fed up with staff leading to seclusion
(Patient) being grabbed by staff and secluded
(Patient) being scared of what he may do to people
(Patient) being threatened with seclusion
(Patient) being treated alright whilst in seclusion
(Patient) being treated differently to other patients - racism
(Patient) being treated differently to other patients - victimisation
(Patient) being treated well by most of the staff
(Patient) being used to being powerless when being secluded
(Patient) belief he was secluded because of staff paranoia
(Patient) belief that he cannot do anything differently to prevent seclusion as it is staffs fault
(Patient) belief that he had control over when he could come out of seclusion
(Patient) belief that HSS is trying to change him as a person
(Patient) belief that it is the system and not him that is wrong
(Patient) belief that particular staff are not genuine
(Patient) belief that particular staff need 'splitting' as together they 'act the bollocks'
(Patient) belief that seclusion is used as a punishment
(Patient) belief that seclusion is used to try and change people by getting them to reflect on what has gone wrong
(Patient) belief that staff are not genuine - full of lies
(Patient) belief that staff expect him to back down from confrontation
(Patient) belief that staff paranoid that patient will act out
(Patient) belief that staff should attend immediately to patient summoning them
(Patient) belief that staff thinks he is hard because of a tattoo

(Patient) belief that staff were making derogatory comments to him whilst he was in seclusion

(Patient) belief that staff whom he had threatened may have been reprimanded for their behaviour towards him

(Patient) belief that there are certain behaviours that will always result in seclusion

(Patient) borstal dealing with complaints fairer than high secure care

(Patient) borstal more disciplined than high secure care

(Patient) comparing own dangerousness to that of others who have seriously offended

(Patient) complaints about staff attitude and behaviour

(Patient) concern about consequences of assaulting others

(Patient) concern about lack of progress due to incidents, yet serious offenders progress if settled

(Patient) concerns about meeting staff he assaulted post seclusion

(Patient) concerns about not being able to summon staff if required in seclusion

(Patient) consequences for questioning staff behaviour

(Patient) consequences of assaulting staff

(Patient) constantly looking for ligature points in seclusion room (desire to self harm)

(Patient) coping with the frustrations of staff lack of trust

(Patient) decision to stop dirty protest due to concern for nurses having to intervene if he had bad reaction to medication

(Patient) deliberately acting out to ensure isolation from peers when in prison (block)

(Patient) describing difference between block in HMP and seclusion in HSS = time off sentence v stay longer

(Patient) describing his own illness

(Patient) description of being sent to HSS from HMP as 'being nutted off'

(Patient) description of being 'twisted up' during restraint on commencement of seclusion

(Patient) description of being 'twisted up' when being 'fed' out of seclusion room

(Patient) description of C&R holds as 'locks'

(Patient) description of having shoes dragged off by staff on being secluded

(Patient) description of interaction with staff based upon perceived ability to fight them

(Patient) description of one staff as being a 'cunt'

(Patient) description of own reflections on his life - not pleasant re-living the bad parts

(Patient) description of particular staff who think they are hard men

(Patient) description of restraint following assault on staff

(Patient) description of seclusion room as 'the box'

(Patient) description of self as lion in a cage

(Patient) desire for respect from staff

(Patient) desire to get out of HSS preventing retaliation against staff

(Patient) desire to get out of HSS preventing use of violence

(Patient) desire to have face to face altercation with staff - but realising this would lengthen seclusion regime

(Patient) desire to self isolate even out of seclusion

(Patient) desire to stay in own room until discharge, keeping away from peers and staff

(Patient) determination and strength of will

(Patient) didn't give patient opportunity to walk unrestrained to seclusion room

(Patient) difficulty in summoning staff when in seclusion

(Patient) dirty protest - rationale being if you treat me like shit then your ward can smell of shit

(Patient) dirty protest as a result of staff withdrawing personal possessions (videotapes)

(Patient) discriminatory treatment giving rise to feelings of violence

(Patient) dislike of going into seclusion

(Patient) dislike of particular peer whom he considers cocky because of his size

(Patient) dislike of way staff talk to patients

(Patient) distressed and disturbed about having rub-down searches
(Patient) encouraging staff to fight with him
(Patient) enjoying access to gym whilst in seclusion
(Patient) exercising all day in seclusion as part of physical training regime
(Patient) exercise to counter the weight gain effects of medication
(Patient) experience of seclusion as positive
(Patient) explanation for seclusion given by doctors
(Patient) expresses strong feelings about staff inattentiveness
(Patient) expressing own ability to fight staff
(Patient) external concerns affecting behaviour
(Patient) external concerns relating to being in high secure care
(Patient) external demands upon behaviour giving rise to frustration and bitterness
(Patient) external demands upon patient leading to feelings of being pushed
(Patient) externally imposed expectations on his behaviour with temporal link
(Patient) familiarity with staff control over patients
(Patient) feeling angry after brooding on previous incident
(Patient) feeling bitter about temporal conditions for progress placed upon him
(Patient) feeling bitter that chance of progress had gone following incident
(Patient) feeling bitterness due to some staff not trusting him whilst in seclusion
(Patient) feeling frustrated about temporal conditions for progress placed upon him
(Patient) feeling intimidated by staff when being searched
(Patient) feeling more relaxed in seclusion (asked to be placed in seclusion)
(Patient) feeling of being discriminated against when involved in altercations
(Patient) feeling of being sexually assaulted when searched under restraint
(Patient) feeling of injustice
(Patient) feeling violated at having a rub-down search (exposed, naked)
(Patient) feelings of anger at being treated as serious offender and years passing by
(Patient) feelings of anger at having lip cut by staff
(Patient) feelings of being brainwashed after several weeks in seclusion (funny thoughts !!)
(Patient) feelings of discrimination re duration of seclusion compared to others behaviours
(Patient) feelings of hopelessness
(Patient) feelings of humiliation when having rub down search
(Patient) feelings of intense anger towards staff
(Patient) feelings of intimidation by staff
(Patient) feelings of wanting to assault staff when getting a search
(Patient) finds difficulty in being treated as though he was an offender
(Patient) forced use of restraint en-route to seclusion
(Patient) frustration arising from being in seclusion
(Patient) frustration at delays in meeting everyday needs in seclusion
(Patient) frustration at having to wait for a light for cigarette in seclusion
(Patient) frustration at lack of fresh air and ability to smoke in seclusion
(Patient) frustration when having to ask for basic needs to be met in seclusion
(Patient) frustration with complaints process
(Patient) frustrations leading to perception of punishment
(Patient) futility and resignation
(Patient) get used to having to rely on others for basic needs being met when in seclusion

(Patient) gray seclusion room walls contributing to depressed mood
(Patient) hard accepting being treated as though you were a serious offender
(Patient) having to bang on door in seclusion to summon staff
(Patient) having to rely on others to meet basic needs in prison (segregation)
(Patient) having to take prescribed medication for seclusion to end
(Patient) hopes of progressing
(Patient) hot environment being worst aspect of seclusion
(Patient) how patient is feeling can influence possible response to threats of seclusion
(Patient) humiliation on being searched
(Patient) implied threats to assault staff if they open the door
(Patient) improve environment by providing means of summoning staff
(Patient) inability to offer opinion as to whether dirty protest behaviour contributed to length of seclusion episode
(Patient) imbalance of power between staff and patients
(Patient) inconsistencies in reasons given for initiating seclusion
(Patient) inconsistencies in staff approach leading to delays in getting out of seclusion
(Patient) inconsistency in staff applying restraint when patient coming out of seclusion room
(Patient) inconsistency in staff approaches and interventions
(Patient) inconsistency in treatment of patients in seclusion
(Patient) inconsistent staff approaches hindering progress
(Patient) inconsistent staff approaches hurt feelings
(Patient) inconsistent use of physical restraint when offering social contact
(Patient) increased security restrictions since inquiry
(Patient) indication that he would have used violence if not secluded
(Patient) ineffectiveness of mental health act commission in helping patients
(Patient) ineffectiveness of solicitors in helping patients
(Patient) inevitability of seclusion once physical restraint is used
(Patient) inevitability of seclusion once restraint used
(Patient) informed of seclusion due to threats against staff
(Patient) injured by staff
(Patient) justification for assaulting staff due to staff grabbing patient first
(Patient) justifying past violence
(Patient) labelling of his illness by doctors
(Patient) lack of access to fresh air in seclusion
(Patient) lack of fairness in being restrained for defending self
(Patient) lack of fresh air in seclusion
(Patient) lack of progress in HSS despite no index offence compared to serious offenders
(Patient) lack of recognition of how his actions could be perceived as threatening
(Patient) lack of recognition of own behaviour leading to seclusion
(Patient) lack of staff trust in patient leading to use of physical restraint
(Patient) lack of therapy in seclusion
(Patient) legal consequences to behaviour
(Patient) limited access to tobacco in seclusion
(Patient) losing composure and assaulting staff
(Patient) loss of self control
(Patient) male staff trying to belittle patients to show off to female colleagues
(Patient) malevolence or benevolence of staff attitude dependent upon like or dislike of patient

(Patient) managing to live with different staff approaches to physical restraint
(Patient) medication contributing to excessive sleeping in seclusion
(Patient) more concerned about rub-down search than being secluded
(Patient) more conditions for progress placed upon him than upon other patients
(Patient) need for better means of summoning staff when in seclusion
(Patient) need for better ventilation in seclusion rooms
(Patient) need to fight with prison officers in HMP to prevent them 'fucking' with you
(Patient) need to look to the future to prevent lowering of mood in seclusion
(Patient) need to maintain mental strength to prevent lowering of mood in seclusion
(Patient) need to raise own mood in seclusion - 'to get out of that downer'
(Patient) need to self isolate away from idiots
(Patient) negative feelings associated with being searched
(Patient) no animosity towards staff initiating seclusion
(Patient) no concerns about rejoining peer group post seclusion
(Patient) no dissatisfaction with seclusion room environment
(Patient) no preconceived ideas about HSS before he came
(Patient) not caring about time in HMP segregation as it all comes off sentence
(Patient) not having to worry about anything in seclusion
(Patient) not informed of reason for seclusion at time of commencement
(Patient) not interested in occupational therapy whilst in seclusion
(Patient) not progressing by talking to doctors and care team members
(Patient) not resisting seclusion as he wants to get out of HSS
(Patient) not told of how seclusion would be terminated at the time of its commencement
(Patient) not told of reason for seclusion at time of incident
(Patient) noting brutality on previous ward
(Patient) noting difference between HMP segregation and HSS seclusion on time in detention
(Patient) noting of time spent on high dependency areas
(Patient) noting temporality of progress in HSS ('we'll see next year')
(Patient) nursing assistant controlling and directing physical restraint
(Patient) nursing assistants seeking power
(Patient) nursing assistants use of searching as a means of exerting power
(Patient) one staff winds patient up and was responsible for patient destroying own bedroom
(Patient) observations – reasons not given for use
(Patient) observations – left to own devices
(Patient) observations – impact upon activities cause concern
(Patient) observations - NA's more willing to engage
(Patient) observations - staff dismissive
(Patient) observations – not concerned – not intrusive
(Patient) observations – take it or leave it
(Patient) observations – not marked against progress
(Patent) observations – stopped leaving ward
(Patient) observations – annoyed not consulted about implementation
(Patient) observations – imposed without consultation
(Patient) observations – staff ignorant –talking to themselves
(Patient) observations – not worthy of staff time
(Patient) observations - not worthy of engagement

(Patient) observations – staff not interested – just sits in the office

(Patient) observations – apathy and disinterested – accepts restrictions placed upon him

(Patient) observations – annoyance at staff listening in

(Patient) observations – could have ended earlier

(Patient) observations – disagrees with reasons for implementation

(Patient) opinion that everyone can be dangerous

(Patient) opinion that he could have been allowed to walk to seclusion without restraint

(Patient) opinion that he could have knocked out staff if he had wanted to

(Patient) opinion that he doesn't need HSS

(Patient) opinion that he is now less dangerous than previously

(Patient) opinion that he needs structure of a high dependency ward to help him with his problems

(Patient) opinion that nurses should help people not wind them up and play games with people

(Patient) opinion that seclusion has lasted too long

(Patient) opinion that seclusion is used to punish people

(Patient) opinion that staff deliberately withdrew personal property (of sentimental value) in retaliation for patient making complaint about him

(Patient) opinion that staff do not like the smell emanating from dirty protest behaviours

(Patient) opinion that staff listen to him when in seclusion

(Patient) opinion that staff response to situation was not proportionate

(Patient) opinion that staff should be 'struck off' nursing register

(Patient) opinion that staff treated him ok when in seclusion

(Patient) opinion that staff were not justified in jumping on him

(Patient) other patients receiving therapy in seclusion

(Patient) paranoid thoughts after a few weeks in seclusion

(Patient) particular staff as piss takers

(Patient) particular staff being cheeky to colleagues

(Patient) particular staff being helpful and attending to patient when in seclusion

(Patient) particular staff being verbally derogative towards another patient

(Patient) patient expressing ability to fight one particular staff

(Patient) patient perception of seclusion as punishment

(Patient) peer corroboration of staff talking down to patients

(Patient) peer group glad to see him out of seclusion

(Patient) peers not treating him differently when in seclusion

(Patient) perceived lack of progress

(Patient) perceived need to keep out of seclusion by telling self that staff are not worth spending time in seclusion for

(Patient) perception of being secluded for throwing bottle of water at staff

(Patient) perception of consequences for staff if they break from the fold

(Patient) perception of medication as being 'jellyhead' pills

(Patient) perception of need for seclusion room post assault

(Patient) perception of others (staff and peers) as idiots

(Patient) perception of own pathway into high secure care

(Patient) perception of own self control

(Patient) perception of preferential treatment for some patients

(Patient) perception of pressure to conform as the 'moss side culture'

(Patient) perception of previous worse behaviours not leading to seclusion

(Patient) perception of regional differences in attitudes

(Patient) perception of segregation in HMP as punishment

(Patient) perception of staff 'acting the bollocks'

(Patient) perception of staff and peers as clowns

(Patient) perception of staff as being cheeky

(Patient) perception of staff as taking liberties because they are friends with the charge nurse

(Patient) perception of staff as 'wannabee criminals'

(Patient) perception of staff deliberately pushing into him

(Patient) perception of staff sticking together - pissing in same pot

(Patient) perception of staff trying to make themselves look tough

(Patient) perception of staff willing to help patients

(Patient) perception of staff writing lies in the clinical notes

(Patient) perception of throwing bottle of water as akin to chucking dummy out of pram

(Patient) perception of unqualified staff abusing power

(Patient) perception of why seclusion continued

(Patient) perception of younger patients as having bad attitudes

(Patient) perception that he has been secluded for same behaviours as peers - who have not been secluded

(Patient) perception that he is playing the system to get out of HSS

(Patient) perception that he will be restrained and secluded after altercation with peer - but peer not

(Patient) perception that his being secluded for hitting a peer would depend on which peer he hit

(Patient) perception that hitting a staff would always result in seclusion

(Patient) perception that HSS won't change him as a person

(Patient) perception that neuroleptic drugs have been tested on him

(Patient) perception that one staff deliberately winds patients up when in seclusion

(Patient) perception that patients progress if they are quiet

(Patient) perception that some patients 'get away' with assaulting staff

(Patient) perception that staff who had been threatened were giving him time to calm down before engaging with him in seclusion

(Patient) perception that the authorities have 'fucked' him up and taken the piss

(Patient) perception that there was nothing staff could have done to prevent his seclusion

(Patient) perceptions on racism

(Patient) persecution

(Patient) plan to tell doctor that he wants to come out of seclusion but wants to isolate self from others

(Patient) possible responses to the threat of seclusion

(Patient) preferring to be in seclusion than own room - locked door matters

(Patient) pressures placed upon patient by the organisation

(Patient) presumption that staff treat others as bad as they treat him

(Patient) prevention of incident if the staff he dislikes had kept away from him

(Patient) previous placement in segregation in HMP - also relaxing

(Patient) prison isolation = no brainwashing, HSS seclusion = brainwashing

(Patient) prison officers perception of high secure care

(Patient) progress dependent upon temporal expectations on behaviour

(Patient) public concerns about having sex offenders and paedophiles on doorstep

(Patient) public perception of HSS as a nuisance

(Patient) pulling self out of downer by being strong minded and looking to the future

(Patient) questioning of use of physical restraint

(Patient) rationale for staff deliberate action being lack of apology

(Patient) realisation of seclusion once moved to cleared side room

(Patient) realisation of seriousness of being sent to high secure care
(Patient) realisation that incident has damaged prospects of transfer
(Patient) reasons why he came to high secure care
(Patient) recall of past life events playing on patients mind whilst in seclusion
(Patient) recognising long term nature of his ongoing seclusion regimes (18 months)
(Patient) recognising things he could have done that could have prevented seclusion
(Patient) recognition of alternative possible courses of action
(Patient) recognition of behaviours required to progress out of HSS
(Patient) recognition of different attitudes of staff - some Ok with him, some whom he dislikes
(Patient) recognition of external control over future
(Patient) recognition of need to get out of seclusion before being able to progress out of HSS
(Patient) recognition of past incidents
(Patient) recognition of seclusion as consequence of using violence
(Patient) recognition of some staff being helpful
(Patient) recognition of temporality of being in high secure care (not getting any younger)
(Patient) recognition of time passing whilst in HSS
(Patient) recognition that can't always walk away from provocation as we all have breaking points
(Patient) recognition that he needed to be secluded at the time that he was
(Patient) recognition that own behaviour was wrong
(Patient) recognition that similar incidents in future may result in further seclusion
(Patient) recognition that staff allowed him out of seclusion when he wanted to
(Patient) recognition that what staff write about in the notes can affect progress
(Patient) reflecting on life when initially secluded leading to lowering of mood
(Patient) reflection causing patient to feel bad
(Patient) refraining from violence due to it hindering progress out of HSS
(Patient) refraining from violence due to staff not being worth hindering progress for
(Patient) refraining from violence not helping progress
(Patient) refusing rub-down search due to lack of privacy
(Patient) reliance on staff for daily tasks when in seclusion
(Patient) reluctance to exact revenge
(Patient) reluctance to resort to violence
(Patient) reluctant acceptance of different staff approaches
(Patient) requesting interviewer to use his authority to progress his care
(Patient) requirement for settled behaviour for seclusion to end
(Patient) resisting restraint after being jumped on
(Patient) rub-down searches lacking in dignity and respect
(Patient) sadness associated with seclusion damaging progress
(Patient) secluded following being assaulted without provocation
(Patient) secluded for defending self from physical interventions from staff
(Patient) seclusion as a consequence for assaulting patients
(Patient) seclusion as means of isolation with mentally ill
(Patient) seclusion as opportunity to reflect
(Patient) seclusion as positive experience in allowing for reflection on past life events
(Patient) seclusion as rehabilitative
(Patient) seclusion as the only thing that relaxes patient
(Patient) seclusion as time to consider future

(Patient) seclusion as treatment
(Patient) seclusion extended due to incident of arguing with a staff
(Patient) seclusion giving rise to sense of relief due to not having to talk to staff
(Patient) seclusion longer for assaults on staff
(Patient) seclusion of patients who are ill and experiencing psychotic symptoms
(Patient) seclusion seen as positive in that it can help you calm down
(Patient) seeking legal redress over decision to seclude him
(Patient) self justification for use of seclusion due to retaliation
(Patient) self professed ability to fight staff
(Patient) serious offenders progressing quicker than self (minor offender)
(Patient) sexualising of anger towards others when having a rub-down search
(Patient) social contact dependent upon settled behaviour
(Patient) some staff wanting to use physical restraint
(Patient) some team leaders allowing nursing assistants to have power
(Patient) spending time in seclusion by exercising
(Patient) spending time in seclusion thinking about things (nothing specific)
(Patient) staff arrogance towards patients
(Patient) staff attempts at intimidation
(Patient) staff behavioural response to being assaulted
(Patient) staff being 'cheeky' to patient whilst he is in seclusion
(Patient) staff bragging about self
(Patient) staff can prevent seclusion by listening, understanding patient and showing empathy
(Patient) staff claiming that patient was jumped on because he was angry and disturbed
(Patient) staff delays in meeting patient immediate needs
(Patient) staff dismissive of patient request for fresh air when in seclusion
(Patient) staff disrespect towards patients
(Patient) staff giving hard time to those patients they don't like
(Patient) staff helping patients they like
(Patient) staff jumping on patient after he threw a bottle of water
(Patient) staff justification for using seclusion
(Patient) staff laughing at patient when becoming angry at the need for a search
(Patient) staff lying about threatening comments to keep patient in seclusion
(Patient) staff making right decision to seclude him
(Patient) staff not asking consent before searching
(Patient) staff only considering one version of events
(Patient) staff presenting as arrogant
(Patient) staff retribution by not attending to patient on request in seclusion
(Patient) staff siding with staff - even the nursing assistants
(Patient) staff sometimes too eager to use seclusion
(Patient) staff taking staff side when they know patient is right
(Patient) staff talking down to patient whilst he is in seclusion
(Patient) staff talking down to patients
(Patient) staff telling patient to fuck off
(Patient) staff throwing weight around
(Patient) staff treating patient the same post seclusion
(Patient) staff treating patient with dignity whilst in seclusion

(Patient) staff inattentive to patient request for attention in seclusion

(Patient) staff view of patient behaviour as assault

(Patient) staff will always side with their colleagues

(Patient) staff worried about patient acting out if not secluded

(Patient) staff wrong to use seclusion

(Patient) staffs view that patients are always in the wrong

(Patient) start reflecting on life when initially secluded

(Patient) stated need to keep away from idiots as a coping strategy for preventing getting into trouble

(Patient) talking about staff social relationships with each other and which staff hang around with each other

(Patient) talking of assaulting another patient before the other patient gets the opportunity to assault him

(Patient) temporality - having 'done' time in high secure care

(Patient) temporality – expectations of remaining incident free

(Patient) temporality – detention not in own hands

(Patient) temporality – waiting for tribunal

(Patient) temporality – seclusion temporal marker

(Patient) temporality – delays in treatment

(Patient) temporality – progress by ward placement

(Patient) temporality – planning not possible

(Patient) temporality – seclusion – don't know when ending

(Patient) temporality – seclusion – lasting too long

(Patient) thankful of staff applying correct C&R techniques

(Patient) the need for a locked door when calming down in case of loss of self control

(Patient) the need to fight with prison officers in HMP to gain their respect

(Patient) the role of high secure hospitals

(Patient) the worst thing about seclusion being the reflecting upon life and the subsequent depression this brings

(Patient) things getting on top of patient prior to seclusion

(Patient) thinking about family when in seclusion

(Patient) tightening of security since Fallon inquiry

(Patient) TILT bringing in restrictions on staff similar to those of patients - no them and us now

(Patient) time in seclusion spent escaping from ward pressures (getting away from it)

(Patient) time in seclusion spent listening to radio and watching TV

(Patient) time in seclusion spent sleeping a lot to pass the time

(Patient) time spent in seclusion cleaning room

(Patient) time spent in seclusion thinking of how to influence RMO to help progress

(Patient) treatment in seclusion as punishment - not seclusion itself

(Patient) trying to help peer sort his life out

(Patient) trying to walk away from confrontation with staff due to potential effects upon future

(Patient) trying to walk away from provocative situations with staff

(Patient) unable to comment on seclusion as either positive or negative

(Patient) unjustly secluded following being assaulted

(Patient) unprovoked assault by other patient

(Patient) unspecific threats to staff if they approach patient

(Patient) unwarranted use of restraint

(Patient) use of a tennis ball to occupy time

(Patient) use of complaints as means of getting his side of story told

(Patient) use of exercise in seclusion to keep physical strength

(Patient) use of exercise and training to lift mood
(Patient) use of exercise in seclusion as means of escaping from pressures of interacting with people
(Patient) use of external advocacy supports to air grievances
(Patient) use of family as coping support
(Patient) use of family for support via telephone when in seclusion
(Patient) use of locked door as a control measure to prevent loss of self control
(Patient) use of medication to make self feel good
(Patient) use of seclusion as a means of separation
(Patient) use of seclusion not uniform for same behaviours
(Patient) use of seclusion room as punitive compared to own bedroom
(Patient) use of term 'box' to describe seclusion room
(Patient) use of violence after staff provocation and staff cut his lip and arm
(Patient) use of violence as retaliation for being assaulted
(Patient) use of violence because of staff attempts to grab violently
(Patient) use of violence in self defence
(Patient) use of violence once patient realised seclusion was inevitable
(Patient) use of violence to defend self
(Patient) use of 'we' when talking about ward - sense of community
(Patient) usual for patient to be secluded following assault on staff
(Patient) victimisation
(Patient) view of mentally ill as unpredictable
(Patient) view of seclusion as deliberate attempt to punish
(Patient) view that assault on staff leads to longer in seclusion
(Patient) view that he could not have done anything differently to prevent seclusion
(Patient) view that he should be allowed home to visit sick relatives
(Patient) view that he should be in lower secure setting (taking meds, not bizarre, not violent)
(Patient) view that physical restraint was unwarranted
(Patient) view that refraining from seeking revenge on previous assaulters has not helped progress
(Patient) view that seclusion could have been terminated earlier
(Patient) view that seclusion lasted too long
(Patient) view that seclusion would be reduced if staff were more helpful and respectful
(Patient) view that staff did not need to use seclusion
(Patient) view that staff was in wrong for trying to grab him
(Patient) view that there are tariffs for behaviours in seclusion - not terminated when patient is settled
(Patient) wanting to be in seclusion
(Patient) wanting to kill staff for deliberately pushing into him
(Patient) was secluded due to being threat to staff or patients
(Patient) when in seclusion staff don't ask patient if he feels more relaxed
(Patient) when is seclusion staff don't ask patient why he felt need to be secluded
(Patient) when secluded had feelings of animosity towards those he had threatened (leading to use of seclusion)
(Patient) willingness to offer advice to younger patients to prevent them going to prison again
(Patient) would have acted out to ensure he was secluded
(Patient) would have liked a TV in his room
(Patient) would like more access to gym whilst in seclusion

APPENDIX 7

(Staff) a move away from a blame culture
(Staff) ability of some staff to de-escalate situations with difficult patients
(Staff) ability of some staff to work with difficult patients
(Staff) able to offer opinion
(Staff) accountable to external monitoring around seclusion
(Staff) aiming for team decisions to progress seclusion patients
(Staff) allowing patient time in seclusion to calm down and be on his own
(Staff) anxiety whilst intervening to get a patient into seclusion
(Staff) apprehension when intervening despite patient guarantees not to assault
(Staff) aroused and ready to respond
(Staff) ascertaining views of team about progressing with seclusion patient
(Staff) High secure care as lacking long-standing customs and practice
(Staff) High secure care becoming more transparent and willing to share its practice
(Staff) High secure care historically lacking its own identity
(Staff) High secure care historically more boundaried
(Staff) assessing compliance by making patient sit on bed
(Staff) at times not getting settled patients out of seclusion until challenges by senior managers
(Staff) attempts at de-escalation through engagement
(Staff) attendance or absence from work related to feelings of safety
(Staff) auditory hallucinations as a barrier to communication
(Staff) availability of seclusion as comfort blanket for staff
(Staff) awareness of how own feelings and anxieties when dealing with disturbed patients
(Staff) balance between autocratic and collaborative leadership and motivation styles
(Staff) balance within care team
(Staff) becoming frustrated when others don't care as much as self
(Staff) becoming part of the culture - blending in
(Staff) being criticised by staff for getting patients out of seclusion
(Staff) being held accountability for practice
(Staff) being under pressure from external scrutiny of practice
(Staff) belief that one should always reflect on or question own practice
(Staff) best course of action to seclude without recourse to restraint
(Staff) blurring of boundaries following Blom Cooper inquiry
(Staff) care team ability to challenge seclusion practice
(Staff) care team having shared vision and goals
(Staff) care team sharing common ethos
(Staff) care team striving to improve seclusion practice and seeking alternatives
(Staff) care team taking responsibility for their decisions
(Staff) care teams taking responsibility for their decision making
(Staff) caring about the job
(Staff) caring attitude and approach
(Staff) caring passionately for his staff
(Staff) caring passionately for patients
(Staff) challenging custom and practice (one pt up at a time)
(Staff) challenging custom and practice through risk assessment
(Staff) change in attitude towards use of physical restraint
(Staff) change in attitude towards use of restraint and seclusion

(Staff) change in culture regarding physical restraint
(Staff) change of focus from organisational safety to one of promoting best practice and taking risks
(Staff) changing organisational focus over time
(Staff) changing perception of decision in light of future behaviour
(Staff) changing public image of HSS as practice has become transparent
(Staff) changing the culture
(Staff) choice of staff when intervening to reduce own stress
(Staff) choosing colleagues to relieve anxiety when intervening with disturbed patient
(Staff) coaxing patient out of seclusion
(Staff) collaborative team decision making giving staff confidence
(Staff) concern for physical state of patient following days of being tormented by voices
(Staff) concerned at patient presentation
(Staff) concerns for physical environment if patient becomes violent
(Staff) concerns over being blamed
(Staff) concerns over colleagues taking undue risks
(Staff) concerns over patient proximity when on obs
(Staff) concerns over peer group criticism for progressing patients on obs
(Staff) confidence in decision making when reflecting on same
(Staff) confidence in decision to seclude given patients presentation
(Staff) confidence in decision when reflecting back on decision to seclude
(Staff) confidence in own judgement
(Staff) conflict within the team due to some staff tolerating patient behaviour more than others
(Staff) consulting with colleagues about identifying and minimising risks
(Staff) contemporary management of violence and aggression through knowing your patients and having plans
(Staff) contemporary focus on engagement with patients
(Staff) continuing to engage with difficult patients following initiation of seclusion
(Staff) continuing to work towards progress even when difficult
(Staff) controlling the environment by moving a disturbed patient
(Staff) conviction in own decision making
(Staff) coping with guilt of asking staff to take risks
(Staff) criticism of historical customs and practices
(Staff) culture of risk taking towards seclusions
(Staff) decision to open seclusion room door down to individuals own decision about risk management
(Staff) decision to seclude on recognition of patient losing control
(Staff) de-escalation taking significant time to achieve
(Staff) defending own decision despite unwanted outcome
(Staff) depersonalisation of patient by referring to them as an illness
(Staff) depersonalisation of patients in seclusion by referring to them as 'the seclusions' (depersonalisation)
(Staff) describing an attempted patient assault on staff
(Staff) description of a patient losing control
(Staff) description of research site as a closed hospital that you didn't speak about (historical)
(Staff) description of research site as being a well controlled environment (historically)
(Staff) description of patients as difficult and challenging
(Staff) description of patients as difficult and complex
(Staff) description of violent and aggressive patients as difficult and challenging
(Staff) desire for self determination in own role

(Staff) didn't see nursing as a vocation
(Staff) difficulty in accepting failure with a patient
(Staff) difficulty in keeping people on board when faced with challenging patient
(Staff) disappointment that efforts at de-escalation ended in seclusion
(Staff) disappointment that their efforts at intervening had not proved successful
(Staff) disappointment when patient relapses after investing time and effort
(Staff) discussing rationale for care with patient
(Staff) disengage from patient on obs
(Staff) duty of care to take risks
(Staff) effect upon practice of joining NHS trust
(Staff) effects of enquiries on organisation
(Staff) effects of routine on risk taking
(Staff) emotional investment
(Staff) emphasising size and strength of patient
(Staff) engaging with patients as relapse signatures increase
(Staff) excessive workload affecting quality of care to patients in seclusion
(Staff) experience in dealing with high dependency patients affecting intervening strategies
(Staff) experienced staff more likely to break physical barriers when engaging with seclusion patients
(Staff) external accountability for practice
(Staff) external influences on standards of practice
(Staff) external inquiries disempowering nurses
(Staff) external inquiry affecting practice
(Staff) external pressures positively influencing risk taking
(Staff) external scrutiny having positive effects on risk taking
(Staff) external scrutiny of practice
(Staff) failure to adhere to policy by some peers
(Staff) failure to communicate obs levels to patients
(Staff) failure to communicate parameters of obs episode to patients
(Staff) failure when trying to engage with patient to keep him from seclusion
(Staff) fear affecting attitude - making staff 'tough'
(Staff) fear for self when close to patient
(Staff) fear of assault when on obs
(Staff) fear of criticism if engage with patient on obs
(Staff) feeling comfortable with routines
(Staff) feeling de-motivated following backward step with patient
(Staff) feeling disempowered post inquiry
(Staff) feeling guilty for thinking bad of own staff
(Staff) feeling guilty if own actions and decisions led to staff injury
(Staff) feeling intimidated by patient
(Staff) feeling of threat to personal safety
(Staff) feeling passionate about the job
(Staff) feeling sorry for patients
(Staff) feeling uncomfortable with historical use of seclusion
(Staff) feelings of guilt if driving a practice leads to injury to staff
(Staff) feelings of guilt for not intervening at time of incident
(staff) feelings of relief post successful intervention with seclusion patient

(Staff) focus on security over therapy
(Staff) focus upon getting patients to achieve optimal level of functioning
(Staff) forced use of low stimulation area as alternative to seclusion
(Staff) frightened of patients
(Staff) frightening dealing with disturbed behaviour
(Staff) frustration at lack of progress with patients
(Staff) frustration at length of time taken to progress with patient
(Staff) frustration that efforts at de-escalation ended in seclusion
(Staff) frustration that their attempts at intervening had not proved successful
(Staff) gaining the trust of patients
(Staff) general staff opinion of being the best
(Staff) giving patient final chance to change mind on wanting to be secluded
(Staff) gradual reintegration out of seclusion for assessment
(Staff) gradual reintegration out of seclusion with staff support to ease patient anxieties
(Staff) guilt arising from not personally intervening with disturbed patient who was secluded
(Staff) have got the correct balance between maintaining safety and taking risks
(Staff) have got the correct balance between security and therapy
(Staff) having team support in taking risks
(Staff) high levels of anxiety when intervening with someone in seclusion
(Staff) historical care not scientific
(Staff) historical caution about what was said to MHAC on their visits
(Staff) historical contingency planning (what-if scenario)
(Staff) historical focus on keeping things as they were
(Staff) historical focus on maintaining safety
(Staff) historical focus on the organisation not the patient
(Staff) historical inconsistencies in undertaking values based care
(Staff) historical lack of engagement with patients
(Staff) historical lack of guidance about practice
(Staff) historical management of violence through restraint and extended seclusion
(Staff) historical nursing as a custodial role
(Staff) historical over use of seclusion to eliminate risk
(Staff) historical perception of a closed hospital
(Staff) historical pressure on new staff to conform to cultural rules
(Staff) historical view of research site as regimented with a lot of structure
(Staff) historical view of research site regime as similar to old mental health asylums
(Staff) historical view of nursing as custodial with focus on safety
(Staff) historical view of treatment of patients at research site
(Staff) historically being uncomfortable about number of patients secluded
(Staff) historically didn't talk about work in the hospital
(Staff) historically felt more in control
(Staff) historically not having two seclusion patients in social contact together
(Staff) historical lack of external scrutiny
(Staff) historical view of management of patients being strict
(Staff) holding lay perception of HSS before commencing employment
(Staff) how good relationships can affect interaction even when patient is disturbed
(Staff) historical focus was to maintain safety

(Staff) importance of attitude when dealing with disturbed patients
(Staff) importance of building relationships with patients and gaining their trust
(Staff) importance of compliance in assessing risk
(Staff) importance of confidence when dealing with disturbed patients
(Staff) importance of confidence when dealing with disturbed patients (2)
(Staff) importance of continued engagement despite being scared
(Staff) importance of having the right staff to look after seclusion patients
(Staff) importance of listening to concerns of staff
(Staff) importance of need to get medication right
(Staff) importance of not showing fear as this may reinforce patient perception of dangerousness
(Staff) importance of quality over quantity of nursing staff when trying to get patients out of seclusion
(Staff) importance of staff attitude and experience in managing violence and aggression
(Staff) importance of staff familiar with the patient to maintain safety when intervening
(Staff) importance of staff support in progressing clinical agenda
(Staff) importance of the team having confidence in the leader
(Staff) increase in arousal over number of hours
(Staff) increase in hostility in matter of seconds
(Staff) increasing arousal in self when engaged with disturbed patient
(Staff) instructing patient to go to seclusion room
(Staff) internally driven culture change to become more therapeutic
(Staff) intervening to prevent staff being assaulted
(Staff) intervening to protect colleague from possible assault
(Staff) intervention due to patient level of arousal increasing over time
(Staff) interventions from staff sometimes escalating likelihood of violent incident
(Staff) intimidated by patient hostility
(Staff) intimidated by patient size
(Staff) intuition
(Staff) investment in keeping family on board
(Staff) isolating patient in an area to prevent negative effect on ward
(Staff) isolation of patient to prevent negative effect on ward community
(Staff) joining of NHS Trust affecting practice and view of practice
(Staff) justification for seclusion based on presentation of patient
(Staff) justifying patient aggression towards another patient
(Staff) keeping seclusion regime despite patient spending extended time in social contact
(Staff) knowing the risks of not adhering to management plan
(Staff) lack of nursing resources limiting opportunities for engagement with seclusion patients
(Staff) lack of options available when dealing with a patient willing to use violence
(Staff) lack of options in diffusing situation
(Staff) lack of public concern for the patients in HSS
(Staff) lack of support and leadership affecting staff attitudes
(Staff) lessening of pt anxiety required for termination of seclusion
(Staff) less likely to take risks with pts who assault them, compared to pts who assault each other
(Staff) level of violence requiring response by specialist team
(Staff) listening to patient concerns about physical restraint
(Staff) listening to patients as a new concept
(Staff) looking to older and more experienced staff to lead process of opening seclusion room door

(Staff) maintaining engagement and support to patient following initiation of seclusion
(Staff) maintaining engagement with patient throughout seclusion episode
(Staff) maintaining logistics of a seclusion regime to meet patient psychological need
(Staff) maintaining support during seclusion process to help patient calm down
(Staff) making decisions that go against the views of colleagues
(Staff) making unpopular decisions
(Staff) manager being involved in actual risk taking intervention
(Staff) managing patients = caring for patients
(Staff) marked mood changes within minutes
(Staff) more willing to intervene with patients if colleagues are motivated to do so
(Staff) natural desire to help people in distress or crisis
(Staff) natural desire to help people when in distress
(Staff) need for balance between changing culture but also keeping staff on board
(Staff) need for balance between patient interests and safety
(Staff) need for changing culture at the right pace to keep staff on board
(Staff) need for staff backup if intervention goes wrong
(Staff) need for staff to identify if they have the skills to open seclusion room door
(Staff) need to balance pace of change with need to keep staff committed
(Staff) need to be coercive in use of medication with disturbed patients
(Staff) need to break physical barrier of seclusion to maintain engagement
(Staff) need to consider alternative interventions to physical restraint of disturbed patient
(Staff) need to continue working with patient after relapse - not the end of world
(Staff) need to display confidence themselves in order to instil confidence in others
(Staff) need to ensure patient not armed when interacting with peers
(Staff) need to gain control of situation to prevent patient 'running amok'
(Staff) need to have plan in place before terminating seclusion
(Staff) need to have staff familiar to the patient present when opening seclusion door to minimize paranoia
(Staff) need to keep seclusion corridor and area neat and tidy
(Staff) need to listen to staff feelings about patients
(Staff) need to look beyond controlling aspects of the environment to focus on care
(Staff) need to maintain control of situation
(Staff) need to maintain safety when taking risks in progressing patients
(Staff) need to make decisions that are best for patient but also safe
(Staff) need to meet targets giving rise to taking unnecessary risks
(Staff) need to reassure patient that seclusion wouldn't be terminated if he didn't feel ready
(Staff) need to step back and review situation
(Staff) need to support staff to be 'nurses'
(Staff) need to take risks in progressing with patients
(Staff) need to work in same direction as colleagues when intervening with disturbed patient
(Staff) negative effects upon care of having to meet targets and audit standards
(Staff) negotiated planning with patient over several years
(Staff) negotiated care plan to prevent use of restraint
(Staff) negotiated care planning with patients
(Staff) negotiated termination to seclusion with patient who didn't want it terminated
(Staff) negotiated use of low stimulus environment
(Staff) negotiating next steps of plan to prevent need for seclusion

(Staff) no differentiation between managing risks to staff or patient
(Staff) not attributing personalisation when dealing with disturbed patient
(Staff) not being able to act as they would wish
(Staff) not feeling trusted by line managers
(Staff) not having a gung-ho approach to progressing patients in seclusion
(Staff) not perceiving their personal safety to be threatened when dealing with disturbed patient
(Staff) not wanting to increase patient anxiety during incident
(Staff) nurses aversion to taking risks for fear of blame post inquiry
(Staff) nursing attitude dependent upon level of support
(Staff) offering patient support after the need to isolate from his peers when disturbed
(Staff) older and experienced staff more willing to enter seclusion rooms
(Staff) opinion on external criticism
(Staff) organisational survival
(Staff) organisational therapy (keeping the organisation healthy)
(Staff) patient anger as part indication of overall presentation that warranted need for seclusion
(Staff) patient anxious and suspicious when around peer group
(Staff) patient aware of availability of seclusion for his own safety if required
(Staff) patient disengaging from them
(Staff) patient empowerment post inquiry
(Staff) patient fearful of consequences of violence
(Staff) patient fearful of his peer group
(Staff) patient fears of restraint and injection medication on being secluded
(Staff) patient feeling of injustice at being secluded following being assaulted
(Staff) patient feeling of injustice at being secluded without having assaulted
(Staff) patient getting fed up of staff attempts at de-escalation
(Staff) patient giving warning to staff with whom he has a good relationship
(Staff) patient needing time to recharge batteries when tired
(Staff) patient requesting seclusion and threatening assault in order to achieve this
(Staff) patient requiring the security of staff locking the seclusion room
(Staff) patient sweating as part indication of overall presentation that warranted need for seclusion
(Staff) patient testing boundaries
(Staff) patient too aroused and volatile to comprehend implications of seclusion
(Staff) patient unpredictability preventing termination of seclusion
(Staff) patient use of threats to achieve desired goal (to be secluded)
(Staff) patient use of threats to orchestrate initiation of seclusion regime
(Staff) patient use of violence as means of escaping from benevolent staff approaches
(Staff) patient view of staff as custodians
(Staff) patients being central to care process
(Staff) patients in seclusion having to rely on staff
(Staff) patients in seclusion receiving greater multi-disciplinary input and attention
(Staff) patients self secluding
(Staff) patients voluntary use of own room as means of de-stimulation
(Staff) peers treating patients in unprofessional manner
(Staff) peers unprofessional language to patients
(Staff) perceived importance of balanced views (not radical)
(Staff) perceived importance of making right decisions

(Staff) perception of care as being scientific and evidenced based
(Staff) perception of care as being values based
(Staff) perception of care team as cohesive
(Staff) perception of care team as consistent
(Staff) perception of care team as positive
(Staff) perception of open seclusion room door as being a risk
(Staff) perception of own organisational authority within current role
(Staff) perception of self as good at job
(Staff) personal concern about levels of seclusion
(Staff) physical attributes of staff not always used when dealing with disturbed patients
(Staff) plan the staffing before engaging with a seclusion patient
(Staff) plan to intervene and engage with patient as relapse becomes evident
(Staff) playing down process of staff entering seclusion room to minimise patient anxiety
(Staff) point of care delivery
(Staff) positioning of staff to minimise risk when entering seclusion room
(Staff) positive care team discussion about seclusion patients
(Staff) positive changes in practice over time
(Staff) potential for sabotage if not onboard
(Staff) potential for sabotage if staff forced to intervene with patients they didn't want to
(Staff) potential for staff injury when restraining strong patients
(Staff) practice dictated by risk rather than custom and practice
(Staff) public disinterest in HSS practice
(Staff) public not wanting political fall-out from HSS practice
(Staff) quality of staff more important that quantity of staff
(Staff) questioning staffs perception of himself
(Staff) re-affirming support for patient following initiation of seclusion
(Staff) re-affirming with patient the need to move on from previous incident
(Staff) realisation of the need to re-engage with a patient following incident
(Staff) reassurance by physical attributes, attitude and confidence of colleagues
(Staff) recognition of need for active staff role in preventing relapse that may require seclusion
(Staff) recognising likelihood of patient retaliation to being assaulted
(Staff) recognising wrong decision making in light of untoward conclusion
(Staff) recognition for need to use skills to engage and show support and empathy
(Staff) recognition of concerns for personal safety in colleagues
(Staff) recognition of external interest in monitoring use of seclusion
(Staff) recognition of job responsibility when dealing with difficult patient
(Staff) recognition of need to intervene to prevent escalation of disturbed behaviour over time
(Staff) recognition of need to let staff manage situations themselves
(Staff) recognition of need to maintain engagement with patients after being secluded
(Staff) recognition of need to maintain safety when progressing, challenging and taking risks
(Staff) recognition of need to take risks and not just keep people locked up
(Staff) recognition of own responsibility as manager to motivate and gain commitment of staff
(Staff) recognition of patient frustrations at delays in meeting everyday needs in seclusion
(Staff) recognition of patient need for support during association periods
(Staff) recognition of staff contribution to patient violence
(Staff) recognition that at times patients can scare staff

(Staff) recognition that at times staff need to make decisions that may prove unpopular with colleagues

(Staff) recognition that at times the team may need encouraging to make decisions on progressing seclusion patients

(Staff) recognition that external pressures are not likely to diminish

(Staff) recognition that it would be easy to disengage from patients in seclusion

(Staff) recognition that locking door & 'feeding' patient out may increase anxieties & lead to acting out behaviours

(Staff) recognition that not all staff have the same level of skill

(Staff) recognition that risk of violence remains despite assurances from patients (in seclusion)

(Staff) recognition that team don't always make right decision

(Staff) recognition of need at times to be autocratic and dictate practice

(Staff) re-engaging with patient after incident

(Staff) re-establishing relationship with patient following initiation of seclusion

(Staff) reflecting on own actions post incident (decision not to intervene)

(Staff) reflecting on own decision making in light of unwanted outcome

(Staff) reflecting upon own approach at motivating staff

(Staff) reflecting upon whether more could have been done to prevent seclusion

(Staff) relationships with patients becoming strained post incident

(Staff) reluctance of a staff group to get a patient out of seclusion following an incident on that group

(Staff) reluctance to end seclusion on settled patients due to concern of further incidents

(Staff) removing patient from area to reduce his levels of anxiety

(Staff) resolution of incident without recourse to restraint

(Staff) responsibility of role in dealing with aggressive patients

(Staff) restraint not a natural behaviour

(Staff) restraint not an integral part of HSS practice

(Staff) risk of staff injuries when using physical restraint on disturbed patient

(Staff) risks of escalating situation if restraint is used

(Staff) role of manager to question seclusion if notes indicate patient is settled

(Staff) role of managers and senior staff to impress nursing aspect of role

(Staff) role of managers and senior staff to support new staff

(Staff) role of managers and senior staff to support other staff

(Staff) role of non-compliance with medication in disturbed behaviour

(Staff) role of senior nurse to promote positive decision making around seclusion

(Staff) satisfaction in current role

(Staff) seclusion helpful in imposing controls on patients who feel out of control

(Staff) seclusion able to allay patient anxieties concerning peer group

(Staff) seclusion allowing the patient the opportunity of having all his needs met

(Staff) seclusion as an opportunity for patient to collect thoughts

(Staff) seclusion as opportunity for a fresh start with patient

(Staff) seclusion being used as a safety blanket for patient

(Staff) seclusion environment as a barrier to communication and engagement

(Staff) seclusion helpful in removing patient from stressful environment

(Staff) seclusion historically determined by charge nurse

(Staff) seclusion historically lasting longer if assault on staff

(Staff) seclusion historically used for staff benefit

(Staff) seclusion therapeutic in providing support

(Staff) seclusion used following assessment of likelihood of threat being followed through

(Staff) seclusion used for benefit of patient
(Staff) seclusion used to set boundaries on behaviour
(Staff) seeking alternatives to use of seclusion
(Staff) self criticism of decision making around termination of seclusion
(Staff) self-critical of own decision making in light of unwanted outcome
(Staff) sense of achievement on successful de-escalation
(Staff) sense of duty
(Staff) separating patients (after altercation) and assessing situation
(Staff) severity of incident requiring C&R response team
(Staff) shift system leading to inconsistency of approach
(Staff) showing patients trust
(Staff) showing respect and trust to patients in seclusion whilst working to end seclusion
(Staff) significance of personal attributes when working with difficult patients
(Staff) significant changes at research site over past 20+ years
(Staff) significant improvement in staff patient relationships in past 20+ years
(Staff) some staff not got experience in dealing with high dependency patients
(Staff) some staff taking easy option of intervening via door hatch
(Staff) some wards getting more support than others through allocation of resources
(Staff) sometimes underestimate how skilled nurses are in HSS
(Staff) staff anxieties when patient walking to seclusion room
(Staff) staff anxiety when opening seclusion room door
(Staff) staff approaches reinforcing patient perception of their own dangerousness
(Staff) staff attitude changing when frightened (becoming tough)
(Staff) staff being patient focused
(Staff) staff concern about how patient is presenting
(Staff) staff concern about possibility of injury to other staff if he makes wrong decision
(Staff) staff concerned for their safety when dealing with patients (post seclusion) who have assaulted them
(Staff) staff confusion over role as hospital or prison
(Staff) staff critical of managers autocratic approach at progressing with seclusion patients
(Staff) staff exiting seclusion room taking significant time
(Staff) staff fearful of patient being out of seclusion
(Staff) staff gain confidence knowing care team stand by decisions made
(Staff) staff investing time and effort to keep patient out of seclusion
(Staff) staff more willing to engage and intervene if on board and not instructed
(Staff) staff more willing to work with seclusion patients when on-board
(Staff) staff only start questioning their practice after senior managers question it first
(Staff) staff over assessing risk when frightened
(Staff) staff sabotage of work with seclusion patients if not onboard
(Staff) staff seeking alternatives to use of seclusion
(Staff) staff taking time to try and meet patient need
(Staff) staff unhappy about re-socialisation plan for a patient
(Staff) staff working hard to keep patient out of seclusion
(Staff) staff working hard towards getting patients out of seclusion
(Staff) staff working hard towards keeping patients out of seclusion
(Staff) strength of patient making it difficult to restrain
(Staff) structured activity to prevent relapse in neuro-cog patients

(Staff) supporting colleagues in taking risks by being there with them
(Staff) supporting patients to calm down following disturbed behaviour
(Staff) taken risks when driving changes in practice
(Staff) team conclusion that decision to seclude was right one
(Staff) team decision to manage risk and open seclusion room door
(Staff) team support in taking risks
(Staff) team taking responsibility for their decision making
(Staff) termination of seclusion when staff feel it is safe to do so
(Staff) termination of seclusion dependent upon patients level of anxiety
(Staff) termination of seclusion when feel it is safe to do so
(Staff) termination of seclusion when patient able to self isolate
(Staff) threats = risk
(Staff) time spent contemplating about how to reduce use of seclusion
(Staff) treating patients with respect
(Staff) try to use collaborative approach with patients whenever possible
(Staff) trying to keep a balance between progressing difficult patients and keeping staff on board
(Staff) trying to negotiate use of low stimulus environment
(Staff) unimportance of physical size when dealing with disturbed patients
(Staff) unusual patient presentation as concerning
(Staff) use of a cleared room to prevent access to weapons
(Staff) use of advanced statements to allay patient anxieties during seclusion process
(Staff) use of care package to prevent relapse leading to seclusion
(Staff) use of cleared seclusion room due to potential weapons in patients own room
(Staff) use of de-escalation not always successful
(Staff) use of de-escalation over extended period of time to prevent restraint or violence
(Staff) use of de-escalation to manage violent and aggressive behaviour
(Staff) use of engagement to de-escalate
(Staff) use of experience in being supportive to staff
(Staff) use of extended social contact regimes to prevent over stimulation
(Staff) use of familiar staff to patient to reduce paranoia when intervening with patient in seclusion
(Staff) use of increased nursing staff to help terminate seclusion regime
(Staff) use of interpersonal approach to diffuse situation with difficult patients
(Staff) use of knowledge of and relationship with patient to influence intervention strategy and risk taking
(Staff) use of low stimulus environment to diffuse situation
(Staff) use of low stimulus environments to diffuse situation
(Staff) use of low stimulus environment to reduce arousal
(Staff) use of low stimulus environment to remove patient from peers
(Staff) use of personal searches to minimise potential for patient to be armed
(Staff) use of physical restraint to prevent assault
(Staff) use of physical restraint to prevent assault on staff
(Staff) use of relationships and trust to manage violent and aggressive behaviour
(Staff) use of resources to prevent seclusion
(Staff) use of restraint leading to staff injuries
(Staff) use of restraint to prevent imminent violence
(Staff) use of seclusion allowing patients to calm down
(Staff) use of seclusion as a means of de-stimulation and reduction of arousal

(Staff) use of seclusion as a means of providing the patient with an environment in which he feels safe
(Staff) use of seclusion as a supportive measure
(Staff) use of seclusion as means of exerting control over patients who may feel out of control
(Staff) use of seclusion as means of reducing patient stress and pressure
(Staff) use of seclusion as therapeutic intervention
(Staff) use of seclusion based on individual assessment - not predetermined behaviours
(Staff) use of seclusion following expressed anger and threats towards staff
(Staff) use of seclusion for patients benefit
(Staff) use of seclusion to allow patient to settle down
(Staff) use of seclusion to maintain safety
(Staff) use of seclusion to prevent escalation of incident to violence
(Staff) use of seclusion to prevent over-stimulation
(Staff) use of seclusion when imminent risk of violence
(Staff) use of supportive observations to assess risk when in social contact
(Staff) use of tools to help staff identify risk when deciding on termination of seclusion
(Staff) using external pressures as a positive driver for risk taking
(Staff) using knowledge of patient to determine intervention strategy
(Staff) utilising best skilled staff when intervening with disturbed patients
(Staff) values based care = investing in patients
(Staff) view of public being unconcerned as long as no trouble
(Staff) view that decision to seclude was right, despite significant efforts at de-escalating
(Staff) viewing change as evolutionary
(Staff) ward placement as sign of competence in managing difficult patients
(Staff) willing to offer encouragement to patient following initiation of seclusion
(Staff) working hard to get patient engaged following seclusion
(Staff) working hard to getting patient on board with treatment programme
(Staff) working to get patient settled enough to begin social contact
(Staff) working to get patient to not need seclusion as means of safety blanket
(Staff) working with patient to alleviate their anxieties about rejoining peer group
(Staff) working with patient to determine source of anxieties to help alleviate them
(Staff) working with patients to achieve their optimum potential
(Staff) would be easy to disengage from someone once secluded